LONG-TERM CARE SUPPORTS AND SERVICES ADVISORY COMMISSION

MARCH 22, 2006

HANDOUTS

LONG-TERM CARE SUPPORTS AND SERVICES ADVISORY COMMISSION BACKGROUND NOTEBOOK

LONG-TERM CARE COMMISSION
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APPENDICES

Dear Commission Member:

Given that the composition of the Commission is so varied, the Department felt that it would be helpful to provide some background information on the State of Michigan long-term care programs and projects. This information is for reference-use only. It contains the Executive Orders that created the Commission, the contact information for the Commission members, the Long-Term Care Task Force Recommendations, the Single Point of Entry Request for Proposals, grant abstracts, and other similar information that you may find useful.

If there is other information you would think the Commission, as a whole, may want, please provide me with that information and I will see that copies are made.

If you have any questions regarding the information in this book, please contact me at tichnellj@michigan.gov or by phone at 517-335-7803.

Sincerely,

Jacquelyn Tichnell

EXECUTIVE ORDERS

Release Date: June 09, 2005
Last Update: June 09, 2005

EXECUTIVE ORDER No.2005 - 14

DEPARTMENT OF COMMUNITY HEALTH
OFFICE OF LONG-TERM CARE SUPPORTS AND SERVICES
MICHIGAN LONG-TERM CARE SUPPORTS AND SERVICES ADVISORY COMMISSION

WHEREAS, Section 1 of Article V of the Michigan Constitution of 1963 vests the executive power of the State of Michigan in the Governor;

WHEREAS, under Section 8 of Article V of the Michigan Constitution of 1963, the Governor is responsible for taking care that the laws be faithfully executed;

WHEREAS, under Section 8 of Article V of the Michigan Constitution of 1963, each principal department of state government is under the supervision of the Governor unless otherwise provided by the Constitution;

WHEREAS, Michigan's publicly-supported system of long-term care must be provided in an integrated and coordinated manner, and must focus on the provision of adequate supports and services, and care for consumers in an efficient, effective, and accountable manner;

WHEREAS, consumers and the families or advocates involved with and most affected by Medicaid long-term care services and supports should be consulted on an on-going basis about ways to improve the quality and delivery of long-term care services and supports;

WHEREAS, Michigan's long-term care system must seek to provide effective public education about the options and settings for long-term services and supports and provide timely and informed access to those options through person-centered planning;

WHEREAS, the Michigan Medicaid Long-Term Care Task Force established by Executive Order 2004- 1, has completed its work and submitted it's final report and recommendations;

WHEREAS, there is a need to take immediate initial steps to begin moving toward the implementation of recommendations made by the Michigan Medicaid Long-Term Care Task Force;

NOW, THEREFORE, I, Jennifer M. Granholm, Governor of the State of Michigan, by virtue of the power and authority vested in the Governor by the Michigan Constitution of 1963 and Michigan law, order the following:

I. DEFINITIONS
As used in this Order:

A. "Commission" means the Michigan Long-Term Care Supports and Services Advisory Commission created within the Department under this Order.

B. "Department of Community Health" or "Department" means the principal department of state government created as the Department of Mental Health under Section 400 of the Executive Organization Act of 1965, 1965 PA 380, MCL 16.500, and renamed the "Department of Community Health" under Executive Order 1996-1, MCL 330.3101.

C. "Office" means the Michigan Office of Long-Term Care Supports and Services created within the

Department under this Order.

D. “Office of Services to the Aging” means the Office of Services to the Aging created within the Department of Management and Budget under Section 5 of the Older Michiganians Act, 1981 PA 180, MCL 400.585, and transferred to the Department of Community Health by Executive Order 1997-5, MCL 400.224.

E. “Task Force” means the Michigan Medicaid Long-Term Care Task Force created under Executive Order 2004-1.

II. CREATION OF OFFICE OF LONG-TERM CARE SUPPORTS AND SERVICES

A. The Office of Long-Term Care Supports and Services is created within the Department of Community Health. The authority, powers, duties, and functions of the Office, including, but not limited to, budgeting, procurement, and related management functions, shall be performed under the direction and supervision of the Director of the Department.

B. Staff of the Office shall be designated by the Director of the Department as he or she deems appropriate and sufficient to perform the duties and fulfill the responsibilities of the Office under this Order. The Department initially shall be staff by reallocating resources from the following organizational units or programs within the Department:

1. The Health Policy, Regulation, and Professions Administration of the Bureau of Health Professions.

2. The Health Policy, Regulation, and Professions Administration of the Bureau of Health Services.

3. The Medical Services Administration.

4. The Mental Health and Substance Abuse Services Administration.

5. The Office of Services to the Aging.

C. The Office shall be headed by the Director of the Office of Long-Term Care Supports and Services who shall be a member of the state classified service and report to the Director of the Department.

D. The Office shall do all of the following:

1. Administer activities to implement the recommendations of the Task Force.

2. Coordinate state planning for long-term care supports and services.

3. Review and approve long-term care supports and services policy formulated by state departments and agencies for adoption or implementation.

4. Conduct efficiency, effectiveness, and quality assurance reviews of publicly-funded long-term care programs.

5. Identify and make recommendations to the Director of the Department regarding opportunities to increase consumer supports and services, organizational efficiency, and cost-effectiveness within Michigan’s long-term care system.

6. Prepare an annual report for the Director of the Department and the Governor on the progress of implementing the recommendations of the Medicaid Long-Term Care Task Force Report.

7. Oversee the implementation of the single point-of-entry demonstration programs required under Section VI.

E. The Office shall assume the functions performed by the Department's Office of Long-Term Care Supports and Services prior to the effective date of this Order.

III. CREATION OF THE MICHIGAN LONG-TERM CARE SUPPORTS AND SERVICES COMMISSION

A. The Michigan Long-Term Care Supports and Services Advisory Commission is created as an advisory body within the Department as a forum for the discussion of issues relating to the provision of long-term care supports and services in Michigan.

B. The Commission shall consist of 15 members appointed by the Governor, including each of the following:

1. Eight members representing primary or secondary consumers of long-term care supports and services.

2. Three members representing providers of Medicaid-funded long-term care supports and services.

3. Three members representing direct care staff providing long-term care supports and services.

4. One member representing the general public.

C. In addition to the members appointed under Section III.B, the Director of the Department, the Director of the Department of Human Services, the Director of the Department of Labor and Economic Growth, the Director of the Office of Services to the Aging, and the State Long-Term Care Ombudsman, or their designees, shall serve as non-voting ex-officio members of the Commission.

D. Except as otherwise provided in this Section III.D, a member of the Commission appointed under Section III.B shall be appointed to serve for a term of 4 years. To provide for staggered terms, of the members initially appointed under Section III.B, 4 members shall be appointed for a term expiring on May 31, 2006, 4 members shall be appointed for a term expiring on May 31, 2007, 4 members shall be appointed for a term expiring on May 31, 2008, and 3 members shall be appointed for a term expiring on May 31, 2009. A member appointed under Section III.B shall continue to serve until a successor is appointed and qualified.

E. A vacancy on the Commission occurring other than by expiration of a term shall be filled in the same manner as the original appointment for the balance of the unexpired term.

F. The Governor shall designate one of the members of the Commission to serve as its Chairperson. The Commission may select from among its members a Vice-Chairperson.

IV. CHARGE TO THE COMMISSION

A. The Commission shall act in an advisory capacity and shall do all of the following:

1. Review and monitor the implementation of recommendations of the Task Force.

2. Review and comment upon quality assurance reviews of Michigan’s long-term care system.

3. Serve in an effective and visible consumer advocacy role for improving the quality of, and access to, long-term care supports and services.

4. Participate in the preparation and review of an on-going, comprehensive statewide plan and resources plan for long-term care supports and services to address and meet identified consumer preferences and needs.

5. Ensure the broadest possible on-going public participation in statewide planning.

6. Promote broad, culturally competent, and effective public education initiatives about long-term care

issues and choices and provide opportunities for direct involvement by the public.

7. Recommend a performance evaluation of the single point of entry demonstration programs required by this Order and make recommendations for the improvement of the single point of entry system in this state.

8. Discuss potential changes in policy that would encourage more effective provision of long-term care supports and services.

B. The Commission shall provide other information, recommendations, or advice relating to long-term care supports and services as requested by the Governor or the Director of the Department.

V. OPERATIONS OF THE COMMISION

A. The Commission shall be staffed and assisted by personnel from the Office, subject to available funding. Any budgeting, procurement, and related management functions of the Commission shall be performed under the direction and supervision of the Director of the Department.

B. The Commission shall adopt procedures consistent with Michigan law and this Order governing its organization and operations.

C. The Commission shall select from among its members a Secretary. Commission staff shall assist the Secretary with recordkeeping responsibilities.

D. A majority of the members serving on the Commission constitutes a quorum for the transaction of the Commission's business. The Commission shall act by a majority vote of its serving members.

E. The Commission shall meet at the call of the Chairperson and as may be provided in procedures adopted by the Commission.

F. The Commission may establish committees and request public participation on workgroups as the Commission deems necessary. The Commission may also adopt, reject, or modify any recommendations proposed by a committee or a workgroup.

G. The Commission may, as appropriate, make inquiries, conduct studies, conduct investigations, hold hearings, and receive comments from the public. The Commission may also consult with outside experts in order to perform its duties, including, but not limited to, experts in the private sector, organized labor, government agencies, and at institutions of higher education.

H. Members of the Commission shall serve without compensation. Members of the Commission may receive reimbursement for necessary travel and expenses according to relevant statutes and the rules and procedures of the Department of Management and Budget and the Civil Service Commission, subject to available funding.

I. The Commission may hire or retain contractors, sub-contractors, advisors, consultants, and agents, and may make and enter into contracts necessary or incidental to the exercise of the powers of the Commission and the performance of its duties as the Director of the Department deems advisable and necessary, in accordance with this Order, and the relevant statutes, rules, and procedures of the Civil Service Commission and the Department of Management and Budget.

J. The Commission may accept donations of labor, services, or other things of value from any public or private agency or person.

K. Members of the Commission shall refer all legal, legislative, and media contacts to the Department.

VI. SINGLE POINT-OF-ENTRY DEMONSTRATION PROGRAMS

A. By June 30, 2006, the Department shall establish not less than 3 single point-of-entry demonstration programs for the delivery of long-term care supports and services. At least one of the programs must be located in an urban area and at least one of the programs must be located in a rural area.

B. The Department shall conduct evaluations of the efficiency and effectiveness of the demonstration programs in meeting expectations for single point-of-entry initiatives identified in the report issued by the Task Force.

C. In developing the single point-of-entry demonstration programs, the Department shall use a collaborative model. The Office of Services to the Aging and the Department of Human Services shall cooperate with the Department in the implementation of this Section IV.

VII. MISCELLANEOUS

A. All departments, committees, commissioners, or officers of this state or of any political subdivision of this state shall give to the Commission, or to any member or representative of the Commission any necessary assistance required by the Commission, or any member or representative of the Commission, in the performance of the duties of the Commission so far as is compatible with its, his, or her duties. Free access shall also be given to any books, records, or documents in its, his, or her custody, relating to matters within the scope of inquiry, study, or investigation of the Commission.

B. To implement the requirements of this Order, the Director of the Department is authorized to establish the internal organization of the Department and allocate and reallocate duties and functions to promote economic and efficient administration and operation of the Department as authorized by Section 7 of the Executive Organization Act of 1965, 1965 PA 380, MCL 16.107.

C. Nothing in this Order shall be construed to change the organization of the executive branch of state government or the assignment of functions among its units in a manner requiring the force of law pursuant to Section 2 of Article 5 of the Michigan Constitution of 1963.

D. As the Medicaid Long-Term Care Task Force created by Executive Order 2004-1 has completed the work for which it was created, the Task Force is abolished. Executive Order 2004-1 is rescinded in its entirety.

E. Any suit, action, or other proceeding lawfully commenced by, against, or before any entity affected by this Order shall not abate by reason of the taking effect of this Order

F. The invalidity of any portion of this Order shall not affect the validity of the remainder of the Order.

This Order is effective upon filing.

Given under my hand and the Great Seal of the State of Michigan this 9th day of June, in the year of our Lord, two thousand and five.

_____
JENNIFER M. GRANHOLM
GOVERNOR

BY THE GOVERNOR:

_____
SECRETARY OF STATE

www.michigan.gov
(To Print: use your browser's print function)

Release Date: February 14, 2006
Last Update: February 14, 2006

EXECUTIVE ORDER No.2006 - 4

AMENDMENT OF EXECUTIVE ORDER 2005-14
MICHIGAN LONG-TERM CARE SUPPORTS AND SERVICES ADVISORY COMMISSION

WHEREAS, Section 1 of Article V of the Michigan Constitution of 1963 vests the executive power of the State of Michigan in the Governor;

WHEREAS, Section 4 of Article V of the Michigan Constitution of 1963 authorizes the establishment of temporary commissions or agencies for special purposes;

WHEREAS, the Michigan Long-Term Care Supports and Services Advisory Commission was created by Executive Order 2005-14;

WHEREAS, it is necessary and desirable to amend Executive Order 2005-14 to expand the membership of the Advisory Commission;

NOW, THEREFORE, I, Jennifer M. Granholm, Governor of the State of Michigan, by virtue of the power and authority vested in the Governor by the Michigan Constitution of 1963 and Michigan law, order the following:

A. Section III.B of Executive Order 2005-14 is amended to read as follows:

"B. The Commission shall consist of 17 members appointed by the Governor, including each of the following:

1. Nine members representing primary or secondary consumers of long-term care supports and services.

2. Three members representing providers of Medicaid-funded long-term care supports and services.

3. Three members representing direct care staff providing long-term care supports and services.

4. Two members representing the general public."

B. Section III.D of Executive Order 2005-14 is amended to read as follows:

"D. Except as otherwise provided in this Section III.D, a member of the Commission appointed under Section III.B shall be appointed to serve for a term of 4 years. To provide for staggered terms, of the members initially appointed under Section III.B, 4 members shall be appointed for a term expiring on December 31, 2006; 4 members shall be appointed for a term expiring on December 31, 2007; 4 members shall be appointed for a term expiring on December 31, 2008; and 5 members shall be appointed for a term expiring on December 31, 2009. A member appointed under Section III.B shall continue to serve until a successor is appointed and qualified."

This Order is effective upon filing.

Given under my hand and the Great Seal of the State of Michigan this 13th day of February, in the year of our Lord, two thousand and six.

_____
JENNIFER M. GRANHOLM
GOVERNOR

BY THE GOVERNOR:

_____

SECRETARY OF STATE

CONTACT LIST

LONG-TERM CARE COMMISSION
CONTACT LIST
3-13-06

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3-13-06

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TASK FORCE REPORT

Modernizing Michigan Medicaid Long-Term Care

Toward an Integrated System of Services and Supports

Final Report of

The Michigan Medicaid Long-Term Care Task Force

Established by Governor Jennifer M. Granholm via Executive Order No. 2004-1

Table of Contents

Preface

This report represents the culmination of many individual and group efforts starting in June 2004. From early on, the Task Force chose to adopt a positive attitude and create a vision of an ideal system as experienced by those the system is designed to serve. We were very aware of the fiscal constraints currently placed on state government. Despite these constraints, we did not lose our focus on the needs and desires of the many elderly, adults or children with disabilities, and caregiving families who are depending on the Task Force to make recommendations for reforming the long-term care system. With increased life expectancy, better medicine, and shifting demographics, many more Michigan citizens are projected to enter the system in coming years than ever before. By necessity as well as commission, the long view is imperative. There is also optimism that with more focus on prevention, chronic care quality outcomes, and support to informal caregivers, many will not need to enter long-term care who would have before. We are confident that these recommendations, if promptly implemented, will help Michigan's long-term care system to become increasingly robust and responsive to the needs of our citizens.

So many people have been involved that we may have omitted a few names of individuals and organizations in the appendix, but I would like to thank everyone for their individual and collective contributions. This has been a truly democratic effort, involving thousands of volunteer hours by hundreds of participants who attended workgroup meetings, composed reports, gave presentations, and shared their personal experience in testimony. Several organizations allowed us to use meeting space, staff time, equipment, and supplies. The number, diversity, and quality of people who were involved with the task force were impressive. We were not able to include all the fine detailed ideas produced by the workgroups, nor did we adopt them all, but we have made all their reports available on the task force web site at: <**www.ihcs.msu.edu/LTC**>. Although the task force's work and formal existence is at an end, our network of relationships will continue to enable us to move forward to face Michigan's ongoing long-term care challenges in new venues.

RoAnne Chaney
Chair, Michigan Medicaid Long-Term Care Task Force
May 2005

Executive Summary

The Michigan Medicaid Long-Term Care Task Force, appointed by Governor Jennifer Granholm, met between June 2004 and May 2005. It was charged with the duty to examine the long-term care (LTC) system and make recommendations to improve quality, expand the reach of home- and community-based services, and reduce barriers to an efficient and effective continuum of LTC services in Michigan. The task force responded by adopting a mission statement that emphasizes the role of consumer choice and by recommending the following policy changes:

1. Require and implement person-centered planning practices throughout the LTC continuum and honor the individual's preferences, choices, and abilities.
2. Improve access by establishing *money follows the person* principles that allow individuals to determine, through an informed choice process, where and how their LTC benefits will be used.
3. Designate locally or regionally-based "Single Point of Entry" (SPE) agencies for consumers of LTC and mandate that applicants for Medicaid funded LTC go through the SPE to apply for services.
4. Strengthen the array of LTC services and supports by removing limits on the settings served by MI Choice waiver services and expanding the list of funded services.
5. Support, implement, and sustain prevention activities through (1) community health principles, (2) caregiver support, and (3) injury control, chronic care management, and palliative care programs that enhance the quality of life, provide person-centered outcomes, and delay or prevent entry into the LTC system.
6. Promote meaningful consumer participation and education in the LTC system by establishing a LTC Commission and informing the public about the available array of options.
7. Establish a new Quality Management System for all LTC programs that includes a consumer advocate and a Long-Term Care Administration that would be responsible for the coordination of policy and practice of long-term care.
8. Build and sustain culturally competent, highly valued, competitively compensated and knowledgeable LTC workforce teams that provide high quality care within a supportive environment and are responsive to consumer needs and choices.
9. Adopt financing structures that maximize resources, promote consumer incentives, and decrease fraud.

The goal of these recommendations is to create an integrated system that appears seamless to the consumer, yet takes maximum advantage of the variety of LTC programs at the local, state, and federal levels. Specific recommendations for reducing barriers to an efficient and effective LTC system include expanding eligibility criteria, creating reimbursement mechanisms based on the acuity level of the consumer, and centralizing supports coordination in the SPE. Citizens will be better informed, involved, and prepared for their LTC needs through public education, participation in statewide and local commissions, and through financial incentives. The state will be better organized by centralizing its LTC planning and administration functions, which are currently scattered across departments.

Appended to this report is a Model Act, which is tentatively titled the "Michigan Long-Term Care Consumer Choice and Quality Improvement Act." It was drafted by a workgroup that sought to embody the task force's ideas in single document that may serve as a basis for legislative action. Although the task force recommendations may be enacted through a variety of means, the model act reinforces the idea that a cohesive, ongoing, and purposeful framework for the provision of LTC is needed in the state.

Introduction: Transforming Michigan's Long-Term Care System

Michigan's publicly-funded long-term care (LTC) system faces a number of challenges, including fragmentation across programs, confusion among consumers and their families seeking access to LTC information and services, an over-reliance on relatively expensive institutional (nursing facility) care, and insufficient mechanisms to allow consumers to receive care in settings of their choice as their preferences and needs change. The state spends a relatively large proportion of its Medicaid long-term care budget on nursing facility services and significantly less on home- and community-based services (such as the MI Choice program). Current federal law, under the Americans with Disabilities Act and the *Olmstead* decision, requires that services for individuals who require LTC services be provided in the most integrated setting of choice possible. There must be an array of options available.

The state government lacks a central unit for coordinating current LTC programs and planning for future needs. The lack of a clearly articulated and consistently implemented strategy is felt on many levels. State residents spend an insufficient amount of time or resources planning for their LTC needs and are largely unprepared when the need (often suddenly) arises. Consumers lack a central place to receive information and support. Services are hard to maintain in some areas because direct care workers are often in short supply due in large part to under-compensation. This chaotic atmosphere will be intensified as waves of "baby boomers" continue to age and enter the system. The system needs to be rebalanced and centralized to serve the increasing needs of current and future consumers.

To address these concerns, the Michigan Medicaid Long-Term Care Task Force was created by Governor Jennifer Granholm via Executive Order No.1-2004 as an advisory body within the Department of Community Health. The charge given the task force by the executive order is to:

1. Review existing reports and reviews of the efficiency and effectiveness of the current mechanisms and funding for the provision of Medicaid long-term care services in Michigan and identify consensus recommendations.

2. Examine and report on the current quality of Medicaid long-term care services in Michigan and make recommendations for improvement in the quality of Medicaid long-term care services and home-based and community-based long-term care services provided in Michigan.

3. Analyze and report on the relationship between state and federal Medicaid long-term care funding and its sustainability over the long term.

4. Identify and recommend benchmarks for measuring successes in this state's provision of Medicaid long-term care services and for expanding options for home-based and community-based long-term care services.

5. Identify and make recommendations to reduce barriers to the creation of and access to an efficient and effective system of a continuum of home-based, community-based, and institutional long-term care services in Michigan.

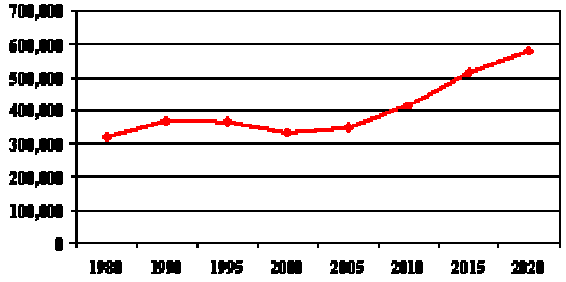
The Task Force first sought to create the vision of an ideal system and then to identify the steps needed to attain it from the current system. The following Vision Statement was adopted at the August 9, 2004 meeting:

> Within the next ten years, Michigan will achieve a high quality, easily accessible system of publicly and privately funded long-term care supports. These supports will include a full array of coordinated services available wherever an individual chooses to live and will be mobilized to meet the needs of each person with a disability or chronic condition, of any age, who needs and wishes to access them.
>
> The arrangement and type of care and supports for each person will be determined by that person. Person-centered planning, which places the person as the central focus of supports and care planning, will be used to determine all facets of care and supports plans. Each person, and his or her chosen family, friends, or professionals, will initiate or re-start the process whenever the person's needs or preferences change.

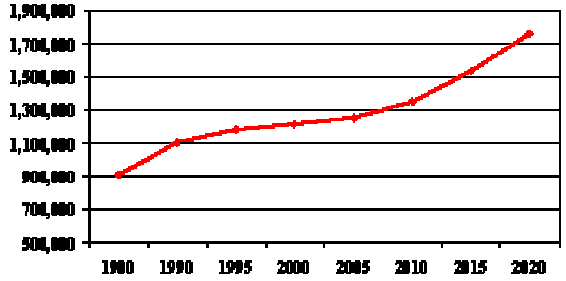
Many challenges exist in the effort to create an efficient and effective system of a continuum of home-based, community-based, and institutional long-term care services. The Task Force has identified some of the key issues through an intensive process of investigation and discussion.

We make the following recommendations to the governor and legislature.

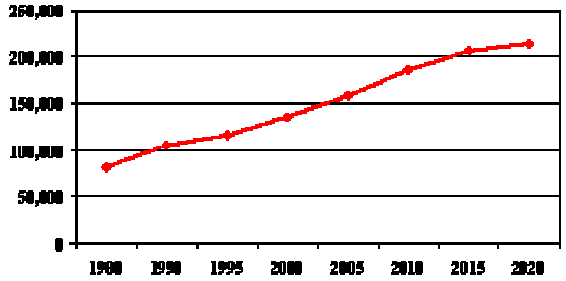
Projected Growth in the 65-69 Year Old Cohort
Sizeable Increases in the Number of Retirees in Michigan



The Escalating Aged Population (Projected)
Persons Over Age 65 in Michigan



Fastest Growing Segment of the Elderly
85 Years and Older in Michigan (Projected)



Michigan Information Center population projections based upon U.S. Census data.

Recommendations

The Task Force makes the following recommendations to improve the quality of Medicaid long-term care services and supports, the quality of home-based and community-based long-term care services and supports, and the quality of life for many citizens of Michigan.

Recommendation # 1: Require and Implement Person-Centered Planning Practices.

Current Issues: Currently, long-term care services are delivered in a medical model manner. Various federal and state required assessment processes and forms are filled out to determine medical needs, financial eligibility, and other information focused on treatment and payment. As the authorizers of service and payment, professionals have the power to drive the care planning process. In some LTC settings, care conferences are often held without the presence of the person who is to receive the care. There may be claims that this practice is more efficient, but by making the consumer a passive receiver of care other problems may develop, such as learned helplessness, depression caused by lack of control over one's own life, and other psychological and physiological problems requiring additional treatment. Experiencing health care problems should not automatically strip people of control over their own lives and Michigan's LTC service delivery needs to reflect this value.

Recommended Actions

The state should require and implement person-centered planning processes in statute and policy throughout the LTC system. As written in the Michigan Mental Health Code, "Person-centered planning" refers to "a process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and that honors the individual's preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals as the individual desires or requires." MCLA 330.1700(g). The process begins as soon as the person enters the LTC system and continues as the person seeks changes. Person-centered planning is designed to allow people to maximize choice and control in their lives. A consumer-chosen supports coordinator/facilitator located at each SPE (see below) will help the consumer navigate through a full range of services, supports, settings, and options.

Strategies / Action Steps

1. Require implementation of person-centered planning in the provision of LTC services and supports. Include options for independent person-centered planning facilitation for all persons in the LTC system.
2. Revise health facility and professional licensing, certification criteria, and continuing education requirements to reflect a commitment to organizational culture change, person-centered processes, cultural competency, cultural sensitivity, and other best practices.
3. Require all Single Point of Entry agencies to establish and utilize person-centered planning in their operations. Review and refine practice guidelines and protocols as part of the first year evaluation of the SPE pilot projects.
4. Include person-centered planning principles in model legislation to amend the Public Health Code.
5. Early in the implementation process, ensure the provision of training on person-centered planning to long-term care providers, regulators, advocates, and consumer.
6. Require a continuous quality improvement process to ensure continuation and future refinement of person-centered planning in all parts of the system.

Benchmarks

1. Legislation requiring person-centered planning in the provision of LTC is passed in the current legislative session.
2. By January 1, 2006, the Department of Community Health, with the involvement of stakeholders, will establish in policy a person-centered planning protocol specific to LTC consumers.
3. Person-centered planning training is developed and provided to LTC providers, regulators, and advocates.
4. By October 1, 2006, each entity providing LTC services will have person-centered policies and training in place.
5. Regulatory survey and program monitoring processes are revised to include a review of the integration of person-centered planning in supports coordination activities.

Recommendation #2: Improve Access by Adopting "Money Follows the Person" Principles.

Current Issues: There are currently different requirements for LTC clients to access services such as nursing homes, MI Choice waiver program, Adult Home Help, Adult Foster Care homes, Homes for the Aged facilities, and Program of All Inclusive Care for the Elderly (PACE). Some programs have a limited amount of access (MI Choice) and other programs are more available (nursing homes). Numerous other programs' unique distinctions (i.e., allowable income levels) make it difficult for consumers to easily shift coverage from one program to another. Current eligibility policy attaches consumer benefits to providers and settings, rather than to individual unique needs.

Recommended Actions

Establish a financing system that allows individuals to determine through an informed choice process where and how their long-term care benefits will be used. Individuals should have a menu of services, settings, and providers from which to choose. "Money follows the person" refers to a system of flexible financing for long-term services that guarantees individuals receive their preferred services and supports in the environment of their choice at all times. The money literally does not belong to nor follow an individual. It is simply a principle that customized services necessary to meet specific needs are available and that consumers drive decisions as they move through the LTC system. Access to different types and amounts of supports becomes seamless and relatively easy from the consumer's perspective and changes with consumer's needs or wishes. "Money follows the person" is a concept that allows an individual to receive necessary services when they want, where they want, and how they want these services delivered.

Strategies / Action Steps

1. Establish consistent spend down provisions across all long-term care settings.
2. Establish funding mechanisms that abide by the "money follows the person" principle.
3. Amend and fund the MI Choice waiver to serve all eligible clients.
4. Establish reimbursement levels that realistically and appropriately reflect the acuity level and need for services and supports the client needs, consistent with federal limitations. (An immediate step would be to remove the current reimbursement cap on the MI Choice waiver.)

Benchmarks

1. Medicaid state plan is amended to establish spend down provisions for community-based LTC settings.

2. Medicaid-funded LTC services and supports are reimbursed based on a case mix basis.

3. Mechanisms are in place to allow consumers to port benefits across the multitude of LTC services and environments of their choice to the extent permitted under federal regulation.

4. Effective October 1, 2005 and quarterly thereafter, MI Choice waiver program enrollment and funding are incrementally increased to meet demand for MI Choice services to eliminate the need for waiting lists.

Recommendation # 3: Create Single Point of Entry Agencies for Consumers.

Current Issues: Michigan citizens needing long-term care services, for themselves or for loved ones, lack a centralized, neutral source of information and assistance. As they navigate through the maze of programs, they may not find the best mix of services and supports to suit their needs. Many simply are placed in nursing facilities because Medicaid provides funding and because they may not be aware of other options. Consumers also need assistance developing their person-centered plans and coordinating their supports.

Recommended Actions

Create locally or regionally-based "Single Point of Entry" (SPE) agencies for consumers of long-term care using person-centered planning process. DCH, or the proposed LTC administration, will oversee the SPE agencies. A SPE is defined as "a system that enables consumers to access long-term and supportive services through one agency or organization. In their broadest forms, these organizations manage access to one or more funding sources and perform a range of activities that may include information and assistance, preliminary screening or triage, nursing facility preadmission screening, assessment of functional capacity and service needs, care planning, service authorization, monitoring, and reassessment." (Source: "Single Entry Point Systems: State Survey Results." Prepared by: Robert Mollica and Jennifer Gillespie, National Academy for State Health Policy).

SPE agencies will provide information, referral, and assistance to individuals seeking LTC services and supports. They will have trained staff and the ability to serve clients who do not speak English. Assistance must include supports coordination and authorizing (but not providing) Medicaid services. They also must serve as a resource on LTC for the community at large, including caregivers. Use of the SPE agency should be mandatory for individuals seeking to access Medicaid funded LTC programs.

Strategies / Action Steps

1. Determine financial eligibility through the appropriate state agency. The process of determining eligibility also helps capture other public and private assistance programs for which the person is eligible. The SPE agencies will provide assistance to consumers in working through the eligibility application process. Single points of entry can facilitate speedier processing and identify barriers to processing. SPE agencies should work with other agencies to resolve barriers found in the system.

2. Make supports coordination a key role of the SPE agencies. Consumers have the ability to change supports coordinators when they feel it is necessary to do so. Individuals should develop their support plans through the person-centered planning process. If the consumer chooses a supports coordinator from outside of the agency, the outside supports coordinator is held to the same restrictions on financial interest and should be held to same standards as SPE

supports coordinator. The SPE retains the responsibility of authorizing services.

a. The consumer can choose to have their supports coordinator broker their services or may broker their own services - whichever they prefer.

b. The SPE agency will develop a protocol to inform consumers of their right to change supports coordinators.

c. Establish methodologies to facilitate consumer control of what, by whom, and how supports are provided. Included will be methodologies for consumers to control their budgets or authorizations.

3. Make LTC transition a function of the SPE agencies. This service helps consumers make decisions about their own lives and facilitates a smooth transition between settings as their needs and preferences change.

4. Balance LTC through proactive choice counseling. The goal of proactive choice counseling is to catch people with LTC needs at key decision points (such as hospital discharge) and provide education and outreach to help them understand their options. Involve hospital administrators and social workers in developing protocols for the two systems to work together. This will involve outreach by the SPE to hospitals to explain their functions and benefits. Do outreach to the local physician community as well as other interested parties (Adult Protective Services, police, and others) working in settings where critical decisions are made about long-term care.

5. Mandate use of the SPE agency for individuals who seek to access Medicaid-funded programs. Individuals who are private pay will be able to access all of the services of the SPE agency. The Information and Referral/Assistance functions will be available to everyone at no cost. Private pay individuals may have to pay a fee to access other SPE services (such services may be covered by long-term care or other insurance, however). LTC providers will be required to inform consumers of the availability of the SPE agency.

6. Make a comprehensive assessment, or level of care tool, (developed by the proposed LTC Administration) available from the SPE agencies to determine functional eligibility for publicly funded LTC programs including Home Help, Home Health, Home and Community Based Services waiver (MI Choice), and nursing facilities. SPE agencies will use the Comprehensive Level of Care Tool for <u>all</u> persons coming to the SPE for assessment. The LTC Administration or MDCH is responsible for the development of the comprehensive tool. The SPE is responsible for ensuring the Preadmission Screening and Annual Resident Review (PAS/ARR) screen is done by the responsible agency when appropriate.

7. Require providers of LTC services to offer the Level of Care Determination Tool to private pay consumers. If a provider feels it cannot perform this assessment for the consumer, the provider should avail itself of the SPE agency's ability to perform this function.

8. Locate functional eligibility determination in the SPE agencies as long as there is aggressive state oversight and quality assurance including: 1) SPE agency required procedures to prevent provider bias and promote appropriate services; 2) SPE agency supervision, monitoring, and review of all assessments and support plans/care coordination; 3) state quality assurance monitoring; and 4) consumer advocate and ombudsman monitoring.

9. The SPE agencies cannot be a direct provider of services to eliminate the tendency to recommend its own services to consumers and any other conflicts of

interest. (An exceptions process must be developed to address service shortfalls, but in no event shall a SPE be a direct provider of Medicaid services.) The case management currently done by Waiver agents would be provided through SPE agencies under this system. The case management done by Department of Human Services (DHS) for Home Help would be provided through SPE agencies in this system. SPE agencies will encompass the entire array of Medicaid funded LTC supports.

10. The funding for defined single points of entry is estimated to be between $60 and $72 million statewide. Of this total, approximately $31 to $36 million represents "shifted" dollars from current case management resources, while the remaining amount reflects newly committed dollars needed for this purpose. The annual state share of newly committed dollars upon full implementation (at the end of year 3) will be $15 to $20 million. The Medicaid administrative matching formula should be used as the means of funding the SPE system.

    The SPE system will be phased-in over a three-year period. The estimate for first year costs for three SPE agencies is $12 to $16 million total funds. The State's GF contribution would be $6 to $8 million of which $3 to $4 million would be cost-shifted. SPEs will be routinely evaluated to ensure the needs of consumers are being met effectively and efficiently. A system wide efficiency gain of 1.7% in LTC expenditures as a result of establishment of single points of entry will fund the entire state system.

11. Develop a standard set of training and certifying criteria for SPE agencies set by the state. By establishing a standard set of certifying criteria, the state will be able to establish quality assurance measures that will provide consistency for consumers and stakeholders. Part of the standard criteria should be a demonstrated knowledge of local and regional resources to supplement Medicaid-funded supports.

12. Standardize the tools used by SPE agencies to allow for portability of benefits for the consumer if they move between regions as well as standardization of data collection for the state.

13. Ensure access to bilingual and culturally competent staff at single points of entry who are trained according to the requirements of the SPE agencies.

14. Implement a quality assurance function focused on the SPE agency that emphasizes, but is not limited to, measures of consumer satisfaction.

15. The state needs to establish a comprehensive oversight system to ensure that all LTC consumers receive those supports and services set forth in their person-centered plan in a timely manner and that the supports and services are of the highest quality possible. Quality in this context will be measured by the consumer's satisfaction or lack thereof with the supports as provided.

16. Expand advocacy processes for all LTC consumers. An advocate must be designated and legally granted the duty and authority to advocate on behalf of individual long-term care consumers, since much expertise is required for effective advocacy. The advocacy function also needs to have a systemic approach to advocacy, similar to that performed by the State Long-Term Care Ombudsman or Michigan Protection and Advocacy Services. This more systemic approach would provide greater opportunity for the advocacy group to determine if there are any patterns of policy violations by SPE agencies or for patterns of misunderstandings of the policies by consumers or providers.

17. Develop grievance and appeals processes that empower LTC consumers to challenge any denial of a requested support or any reduction, termination, or suspension of a currently provided support. The grievance process must be available not only for those issues, but also for issues not typically subject to the appeals process (such as the choice of provider).

Benchmarks

1. SPE agencies initially established in three areas of the state within one year of the issuance of the Task Force report.
2. SPE agencies established throughout the state within three years from the issuance of the Task Force report.
3. In the absence of the LTC Commission, DCH will convene a workgroup of consumers, advocates, providers, and DCH officials that will develop a more detailed list of criteria using the recommendations in this report as a foundation to be met by a SPE agency by July 30, 2005. The workgroup should also approve the regions.
4. DCH or the LTC administration will issue an RFP for early adopters (the first three local SPE agencies). The RFP should require local support and collaboration but not prescribe which agencies can apply as early adopters. The state needs to ensure the recommended agency can meet the standards set by the state. At the time the RFP is issued, MDCH or the LTC Administration should hold briefings for interested agencies on the components of the RFP.
5. DCH, or the LTC Administration, will evaluate early adopters to determine if they are achieving the anticipated results. Information gathered during this evaluation should be used in the development of other SPE agencies.
6. DCH, or the LTC administration, will develop preliminary quality assurance guidelines in time for the RFP that will be issued for the first round of SPE development. This will allow applicants to respond to how they meet quality assurance expectations up front.
7. The outside advocate is adequately funded to assure consumer access in all geographic SPE areas.
8. SPE agencies have local quality assurance boards composed of a majority of consumers, with representation by other stakeholders that are reflective of the communities in which they are located. Functions might include CQI, feedback to governing board, and LTC administration.
9. Agencies responding to the RFP to be an SPE will have an appeals protocol written into their proposals.
10. DCH or the LTC administration will assure that Medicaid Fair Hearing processes are made available to SPE participants.
11. An agency applying to be an SPE should be able to provide a qualified Information and Referral service (such as those certified by AIRS).
12. Hospital discharge planners will contact the SPE at admission to begin the process of assessing needs instead of at discharge.
13. Physicians will coordinate with supports coordinators and consumers to ensure the best outcomes for the consumer. Memoranda of Agreement will be created between hospitals and single points of entry to make this process as smooth as possible.
14. Consumers and their loved ones will have a clear idea of their options.
15. An assessment system and process will be developed that:
    a. Includes a standard minimum intake screen that predicts need for the full array of Medicaid funded LTC programs and efficiently identifies areas for further evaluation.

b. Incorporates person-centered planning as the starting point for assessment and goal development.

c. Implements specific evidence-based assessment protocols when triggered by the minimum intake screen.

d. Includes a comprehensive caregiver assessment when indicated.

e. Utilizes an electronic database that serves as a base for information, documents assessment and planning history, and follows the individual through the full array of long-term care supports.

16. DCH will train single points of entry on the new tool and test it before applying it system wide.

Recommendation # 4: Strengthen the Array of Services and Supports (Expanding the Range of Options).

Current Issues: The Michigan LTC service delivery system is fragmented. Access to community-based LTC settings, services, and supports is limited as a result of caps placed on enrollments and expenditures and financial eligibility. Nursing facility enrollment and expenditures are capped by the availability of a licensed bed and the willingness of a provider to admit a Medicaid recipient. Further limiting access is Michigan policy that establishes patient pay provisions for Medicaid coverage for nursing facility care, provisions that do not exist for home and community-based settings. If an individual is over the income limit the only Medicaid LTC option becomes the nursing facility. There is a lack of affordable setting options between the home and the nursing facility. Michigan policy does not allow individuals who qualify for waivers to receive those services in licensed assisted living settings (adult foster care or homes for the aged). This negates their use as a viable alternative to nursing facility placement. There is a lack of coordination between the health and long-term care service delivery systems, with no incentive for systems to interact.

Chart 1 on the next two pages lists the array of 53 preferred LTC services. It reflects the various existing programs across different funding sources and departments. The consumer wishing to know what services are available is often confused in the process of accessing care.

Chart 2 (on page 13) illustrates the fact that different programs use different criteria for financial eligibility, clinical assessment, quality, oversight, and cost reporting. The combination of a wide array of services with no common eligibility criteria leaves the customer with the need for a "guide" to help them understand, choose, and access needed services. The SPE will act as this "guide".

Ideally the single points of entry would have one eligibility tool. The state should investigate a method to achieve that. Such a future would greatly enhance a seamless experience for the consumer. Individuals whose LTC services are funded with Medicaid dollars should have full access to the same range of services, supports, and settings available to the general public.

Chart 1 Proposed LTC Continuum		Medicaid Eligible Services	HCBW	Home Help	Home Health	OSA OAA	PACE	NH	CMH	DD/MR Waivers	MH State Plan Services
1. Adult Day Care			X			X	X		X		
2. Ambulance		X					X				
3. Assessment			X	X	X	X	X	X	X(PASARR)		X
4. Assisted Living	Includes licensed AFCs/HFAs, services and room/board						X (But no room & board payment)		X	Under CLS*	X (Only in licensed ICF/MR certified settings)
5. Assistive Technology	Includes any device that improves a person's functioning	X	X	(Through Physical Disability Services)			X	Some		X	X
6. Behavioral Health		X					X		X	X	X
7. Case Coordination/ Supports Facilitation	Single coordinator across all settings		X	X		X	X			X	X
8. Caregiver Education						X	X		X	X	
9. Caregiver Support						X	X		X	X	
10. Chiropractic Services		X					X				
11. Chore Services		X	X	X		X	X			Under CLS	Under CLS
12. Chronic Care Management	Focus on consumers and all their needs rather than on medical diagnosis	X			X		X			Uses person-centered planning	Uses person-centered planning
13. Counseling	Includes individual & family		X			X	X	X	X	X	X
14. Dental Services							X			Enhanced	In ICF/MR
15. Diagnostic Services		X					X		X	X	X
16. Emergency Services		X					X		X (Crisis Intervention)	X	X(Crisis Intervention)
17. Employment Services						X (SCSEP-related)			X	X	X(as Habilitation)
18. Expanded State Plan Benefits			X				X				
19. Family Planning Services		X								person-centered planning could cover	person-centered planning could cover
20. Financial Management							X		Guardianship	Under CLS	
21. Fiscal Intermediary				X						X	
22. Gap Filling Services			X			X	X		X		X
23. Hearing & Speech Services	Includes hearing aids	X				X	X			X(Enhanced)	X
24. Home Modification/ Repair	Includes ramps		X			X (Limited)	X		X	X	
25. Homemaker			X	X		X	X		X	Under CLS	
26. Hospice	Includes residential care (room and board)	X					X	X			
27. Hospital Care	Includes in-patient, out-patient	X					X				X
28. Immunizations		X					X				
29. Laboratory Services		X					X				
30. Medical Equipment/ Supplies		X			X	X	X		X	Enhanced	

Chart 1 Proposed LTC Continuum		Medicaid Eligible Services	HCBW	Home Help	Home Health	OSA OAA	PACE	NH	CMH	DD/MR Waivers	MH State Plan Services
31. Medication Management		X	X	X		X	X	X	X	Under CLS	X
32. Nursing Services			X		X		X	X	X	X	X
33. Nursing Facility Services	Includes innovative service delivery models	X					X	X			X
34. Nutrition Services	Includes meal prep, home delivered meals, dietary services		X	X	X	X	X	X		Under CLS	In ICF/MR
35. Personal Assistance Services	Includes personal care, supervision, attendant care	X	X	X	X	X	X	X	X	Under CLS	In ICF/MR
36. Personal Emergency Response			X			X	X			X	
37. Pharmacy		X					X		X (Counseling)	X(Enhanced)	
38. Physician Services	Includes visiting physician	X					X	X			In ICF/MR
39. Podiatric Services		X					X				In ICF/MR
40. Prevention	Includes primary and secondary, and wellness activities					X (Health Screening/ Promotion	X		X		
41. Psychiatric Services		X					X		X		In ICF/MR
42. Refugee Services	Includes interpretive and cultural services					X (2 AAAs Admin. FIA Grants)					
43. Rehabilitation Services		X					X	X	X	X (Habilitation Services)	In ICF/MR
44. Respite	In-home and out-of-home		X			X	X		X	X	
45. Shopping/Errands		X	X	X		X	X			Under CLS	
46. Supervision		X	X				X	X		Under CLS	In ICF/MR
47. Therapies	Includes occupational, physical, speech and maintenance therapies	X					X	X	X		In ICF/MR
48. Training	For consumers & caregivers		X			X	X		X		In ICF/MR
49. Transition Services			X				X		X		Under TCM
50. Transportation	For medical and socialization purposes	X	X			X	X			Under CLS	X
51. Urgent Care Services		X					X				X (Psych.)
52. Ventilator Services		X	X				X	X			In ICF/MR
53. Vision Services	Includes eyeglasses	X					X				In ICF/MR
MEDICAID COST:		**40 current services $1.58 billion**	**$100 million**	**$216 million**	**$25.6 million**	**$85 million**	**$5.3 million**	**$1.2 billion**	**$1.6 billion total MH**	**$5 million**	

*CLS = Community Living Supports are used to increase or maintain personal self-sufficiency, facilitating an individual's achievement of his/her goals of community inclusion and participation, independence or productivity. The supports may be provided in the participant's residence or in community settings (including, but not limited to, libraries, city pools, camps, etc.).

Chart 2

LTC Service	Acuity Assessment Tool	Quality Measures			Cost Data
Nursing Homes[1]	MDS, LTC Eligibility Screen	Family & Resident Satisfaction, Consumer Guide	Quality Indicators (MDS) CMS	OBRA Survey & Complaints (DCH), State Ombudsman (OSA)	Medicaid Cost Reports; Expenditures per person through Medicaid data warehouse
HCBS[3]	MDS, LTC Eligibility Screen, MICIS Screen	Client Satisfaction	Vendor Assessments; Care Plan Monitoring	Grievances & Complaints	Medicaid Cost Reports; Expenditures per person through Medicaid data warehouse
Home Help[4]	DHS Assessments of ADL & IADL Needs	Client Satisfaction	Administrative Hearing Process	Care Plan Monitoring	Expenditures per person through Medicaid data warehouse; Costs per acuity level available through ASCAP random sample studies
Home Health[2]	OASIS (Outcome and Assessment Information Set)	Patient Satisfaction, Consumer Guide	OBQI	Accreditation Medicare State Survey; Complaint Process (DCH)	Expenditures per person through Medicaid data warehouse Cost Reports MC, MA, BC/BS
AFC/HA[4]	DHS Assessments of ADL & IADL Needs	Client Satisfaction	Administrative Hearing Process	Licensing Survey & Complaint Process Care Plan Monitoring	
Hospice[2]		National Hospice Patient Care Family Satisfaction		Licensing Survey, MC State Survey, Accreditation	Expenditures per person through Medicaid data warehouse Cost Reports MC, MA
PACE[4]	LTC Eligibility Screen	Annual & Quarterly Reports to DCH: Satisfaction Surveys, Quality Improvement Program, Grievance & Appeals Report	Survey site visit tool for annual DCH site visit (various items, including random sample of medical records)	CMS PACE monitoring reports (various items, including grievances, unusual incidents, deaths)	Existing PACE will soon be submitting encounter data
OSA: Annual Contracts[3]		Client Satisfaction		Annual Assessment; Performance-Based Contract	National Aging Program Information System; Financial Status Reports
OSA: Purchased Services[3]	MICIS Assessment Tool for LTC Eligibility	Client Satisfaction	Care Plan Monitoring	Assessments; Grievances & Complaints	

1. Nursing Home information from Health Care Association of Michigan;
2. Home Health & Hospice information from Michigan Home Health Association;
3. HCBS and OSA information from Gregory Piaskowski; and
4. Other information from Department of Community Health.

Recommended Actions

Establish an accessible, integrated service system that assures those in need of supports and services have a range of options that allow them to live where they choose. Within an assessed level of need, consumers should have a menu of services and settings to choose from based on their individual preference. Service delivery should be coordinated with existing providers and payers, including private payers, and provided in a wrap-around capacity. (In the case of persons who desire to work, this includes services and supports for vocational and employment activities.)

Strategies /Action Steps

1. Ensure the availability of the health and long-term care services and supports (listed on Chart 1) as part of an integrated system of care.

2. Immediately amend the MI Choice waiver to allow the provision of waiver services to individuals residing in licensed assisted living settings including adult foster care homes and homes for the aged. In addition to this short-term strategy, take measures to ensure that all future comparable Medicaid programs allow supports and services to follow consumers into their preferred living arrangement (money follows the person).

3. Revise Adult Foster Care (AFC) and Homes for the Aged (HFA) rules and regulations to allow for the provision of home health care in AFCs and HFAs on an ongoing basis.

4. Consider creating a HFA statute separate from the Public Health Code.

5. Create an Assisted Living Regulatory and Education Workgroup and charge with the following tasks:

    a. Study and propose modifications to existing adult foster care and home for the aged state statutes and administrative rules for the purpose of ensuring that they meet with the Task Force's stated philosophies and principles of quality and accountability; person-centered planning; money following the person and the availability of Medicaid reimbursement in assisted living (such as the MI Choice waiver or comparable community-based benefits).

    b. Study the array of unlicensed assisted living arrangements. Determine whether existing licensing statutes are appropriately enforced to uphold the philosophies and principles stated above.

    c. In cooperation with other Task Force initiatives, develop consumer education materials to be used by SPE agencies and others to raise consumer awareness about the full array of assisted living services using clear distinctions regarding the applicable state regulations.

    d. Determine the feasibility and appropriateness of developing a legal definition of "assisted living" to allay public confusion as to the meaning of the term and its current use in describing a wide variety of licensed and unlicensed settings.

The task force concluded that the development of a more formal legal definition of "assisted living" is best delayed until the preceding steps have been taken and recommends that the following interim description of the term "assisted living" be universally understood in the Medicaid Long-Term Care Task Force report:

> "The term 'assisted living,' as currently used in Michigan, is a marketing term often used by supported living arrangements such as state licensed adult foster care homes (MCL 400.703 through 400.707), state licensed homes for the aged (MCL333.20106(3)), unlicensed

settings such as housing with services contract establishments (MCL 333.26501(b)) and other supported independent living arrangements."

Benchmarks

1. Array of services is expanded for consumers.
2. Amendment of existing MI Choice waiver to allow the provision of waiver services to individuals in licensed assisted living settings.
3. Creation of an Assisted Living Regulatory and Education workgroup to study issues related to definition, licensure, and regulation, and to suggest ways to amend them to remove barriers that limit services in assisted living facilities.

Recommendation # 5: Support, Implement, and Sustain Prevention Activities through (1) Community Health Principles, (2) Caregiver support, and (3) Injury control, Chronic Care Management, and Palliative Care Programs that Enhance the Quality of Life, Provide Person-Centered Outcomes, and Delay or Prevent Entry in the LTC system.

Current Issues: Strong prevention and caregiver support programs have the potential to increase the quality of life for disabled and elderly citizens and delay entries or shorten stays in the long-term care system. The stress of intensive care giving, in many cases, contributes to increased health care and long-term care needs for the caregivers (such as elderly spouses). Currently, Medicaid does not support preventive health programs and, as the Michigan population ages, the numbers of seniors with multiple chronic diseases will increase unless early interventions are offered.

Recommended Actions

1. Develop and provide incentives for local collaboration, including public health, to actively promote healthy aging through preventive and chronic care for all age groups.
2. Develop and implement legislative/ administrative initiatives to provide financial and other support to caregivers. Natural supports are sustained.
3. Increase the use of "best" chronic care models.

Strategies / Action Steps

Develop a DCH workgroup comprised of legislators, MSA, OSA, DHS, stakeholders / consumers, and others to oversee the collaborative process involving local public health entities engaged in prevention/chronic care. Under the direction of the DCH-led workgroup, local entities will:

1. Convene a broad-based coalition of aging, disability, and other organizations.
2. Review community resources and needs (including prevention, chronic care, and caregiver supports).
3. Identify existing local, culturally competent strategies to address prevention, chronic care needs, and substance abuse.
4. Develop and support programs to address prevention, chronic care, and caregiver supports.
5. Promote the use of culturally competent caregiver training on injury prevention, rights and benefits, and person-centered planning.
6. Develop wrap-around protocols for caregiver/consumer support needs.
7. Develop a public health caregiver support model.
8. Create initiatives and incentives to support caregivers.

9. Identify and promote the use of elements of established models for chronic care management and coordination (e.g., Wagner or ACOVE model).
10. Create incentives for implementing culturally competent chronic care models and protocols.
11. Develop and implement chronic care protocols, including, but not limited to:
    a. medication usage.
    b. identifying abuse and neglect, caregiver burnout/frustration.
    c. caregiver safety and health.
12. Promote the use of Assistive Technology (AT) for consumers and direct care workers/caregivers as a prevention tool.
13. Investigate grant opportunities to pilot chronic care management models.

Benchmarks

1. Needs assessments are conducted and gap analysis reports are completed and reviewed.
2. Local and statewide groups complete plans to address local health and wellness gaps.
3. Executed contracts in place with local existing entities, which are broad-based (including the aging and disability community) to address gaps.
4. Completed workgroup report evaluating progress, outcomes, and identifying next steps.
5. Every local region has a program in place to train caregivers that is culturally competent to the needs and culture of the informal caregiver.
6. Consumer supports are increased and better utilized.
7. Caregiver needs screening incorporated into Medicaid-funded screening instruments.
8. Upon retrospective review, address caregiver needs.
9. Registries completed with processes in place for ongoing updates.
10. Legislative and administrative initiatives are in place and used.
11. Increase in the number of primary and LTC providers trained and adopting the best chronic care and culturally competent models.
12. Medical schools and nursing/ancillary healthcare programs expand their curricula to include chronic care.
13. Increased numbers of students graduating from schools with established chronic care curricula/programs.
14. Increased number of providers using screens and protocol-driven interventions.
15. Increased use of assistive technology as reflected in the person-centered plan.

Recommendation # 6: Promote Meaningful Consumer Participation and Education by Creating a Long-Term Care Commission and Informing the Public about the Available Array of Long-Term Care Options.

A. Long-Term Care Commission

Current Issues: In order to create a long-term care system that is based on consumer choice and control, consumers and their representatives must have a meaningful role in the development and oversight of the system.

Recommended Action

Create a Michigan Long-Term Care Commission to provide meaningful consumer oversight and accountability to the state's reform and rebalancing of the long-term care system.

Strategies / Action Steps

All stakeholders will have meaningful roles in the ongoing planning, design, implementation, and oversight efforts to achieve the recommendations of the Michigan Medicaid Long-Term Care Task

Force and the long-term care efforts of the state. Consumers, families, and their representatives will be the principal participants.

Appointment

The Michigan Long-Term Care Commission will be established in state legislation with the governor appointing members with concurrence of the state senate for three-year staggered terms.

Membership

1) The commission shall consist of twenty-five members appointed by the governor. Commission membership shall consist of fourteen consumers, of which at least fifty percent are primary consumers and of those primary consumers, at least fifty percent shall be users of Medicaid services, the remainder comprised of secondary consumers and consumer organization representatives, seven providers or provider organization representatives, three direct care workers and one member with expertise in LTC research from a university. Overall commission membership shall also reflect the geographic and cultural diversity of the state.

2) One representative each from the SPE network, the State Long-Term Care Ombudsman, the designated protection and advocacy system, the Department of Community Health, the Department of Human Services, and the Department of Labor and Economic Growth, all of whom shall serve in non-voting supporting roles as ex-officio members. Staff shall be provided and shall serve as resources to the commission and shall assist the commission as needed.

3) Voting member terms shall be three years, staggered to ensure continuity and renewable under the appointment process. If a vacancy occurs during the term of a voting member, the governor shall appoint a replacement to serve out the remainder of the term and shall maintain the same composition for the commission as set forth in sec. 1.

4) Commissioners are entitled to receive a stipend, if not otherwise compensated, and reimbursement for actual and necessary expenses while acting as an official representative of the commission as defined by commission policies and procedures. Commission policies and reimbursement shall establish and practice full accommodation to individual support needs of commission members, including their direct care and support workers or personal assistants, support facilitation or other persons serving them as secondary consumers.

5) The governor shall designate one person from among the consumer membership to serve as a chairperson of the commission, who shall serve at the pleasure of the governor.

Authority

1.) Policy and Programs
In partnership with the executive branch and the appropriate department or designated long-term care entity, the Commission will develop and recommend policy regarding all LTC programs including the public awareness and education campaign.

2.) Budget
In partnership with the executive branch and the appropriate department or designated long-term care entity, the Commission will participate in the development of the budget for Michigan's LTC system that implements established policy and meets demonstrated consumer preferences and needs. The commission will make recommendations regarding the same to the legislature.

3.) Spending
The Commission will continuously monitor spending and budget implementation including how well expenditures match policy decisions and initiatives based on demonstrated consumer preferences and needs.

4.) Performance and Quality of Single Point of Entry Agencies
The Commission will help develop and approve quality assurance measures for monitoring the efficiency, effectiveness, and performance of local initiatives including local oversight of and consumer involvement with the SPE agencies. Once the LTC commission is established, it will work with DCH or the LTC administration in the selection and oversight of the agencies.

Using the evaluations and feedback from the performance and quality assurance monitoring done by the department, the Commission will make recommendations to improve the operational performance of SPE agencies and shall make its report and recommendations for improvement to the single point of entry system available to the legislature and the public.

The Commission will play a similar role for all other entities in LTC including new initiatives involved in rebalancing the system.

Benchmarks

1. Passage of authorizing legislation creating LTC Commission.
2. Appointment of Commission members.
3. Reporting by Commission members, both consumers and others that they have the information and support to effectively carry out the Commission's duties.
4. Surveys of consumers using the SPE agencies to demonstrate that the available services and supports and opportunities for consumer choice and control correspond with what they need and want.

B. Public Awareness and Education Campaign

Current Issues: Individuals, families, professionals, and others are not aware of LTC options and are unprepared when a decision needs to be made. Short time frames for decision-making and the complexity of the system, for example, do not allow consumers to fully investigate and understand their options.

Recommended Actions

Educate consumers, families, service providers, and the general population about the array of long-term care options available so that consumers can make informed choices and plan for the future.

The goals of the public awareness and education campaign are:

1. Increase awareness of the SPE agencies through uniform "branding" of local agencies throughout the state (with uniform naming and logo, a single web site, and a geo-routed toll free number).

2. Increase awareness among consumers, prospective consumers, providers, faith-based communities, other community organizations, neighbors, friends, and family members of LTC services that consumers can choose from the array of LTC supports, determine their needs through the person-centered planning process, and have the option to control and direct their supports.

3. Authorize continuing education for professionals (including doctors, nurses, pharmacists, dentists, psychologists, administrators of LTC facilities, discharge planners, social workers, and certified nursing assistants) on the role of the SPE agency, the value of the person-centered planning process, the array of long-term supports available, and options for consumers to direct and control their supports. These professionals can direct individuals to the single point of entry and support them in making informed choices and planning for their future.

4. Assure that state employees involved in any aspect of LTC are provided mandatory training on the value of the person-centered planning process, the array of LTC supports available, and options for consumers to direct and control their supports.

5. Provide an orientation to legislators and their aides and officials in the executive branch on the value of person-centered planning, the array of long-term supports available, and options for consumers to direct and control their supports.

6. Create an educational program for children K-12 to learn about career opportunities in direct care and other aspects of LTC, and the components of the new LTC system (the array of long-term care supports available, the value of the person-centered planning process, and options for consumers to direct and control their supports) so that children can share this information with their family members.

Strategies / Action Steps

1. Develop criteria for and authorize hiring of a social marketing firm to develop a marketing and public awareness campaign that includes the following components:
   - Uniform identity including name and logo for the single point of entry agencies;
   - Public awareness campaign that includes radio and television public service announcements, print ads, brochures, and other appropriate educational materials; and
   - Local media and awareness tool kit that single point of entry agencies can use to outreach to and raise awareness among all stakeholders.

2. Develop criteria for and authorize hiring of a web design firm and an expert in creating materials for the targeted populations (e.g., seniors and people with a variety of disabilities) to design an informative, user friendly web site that can serve as a single point of information regarding LTC in Michigan. This web site will maintain the look, name, and logos developed for the marketing and public awareness campaign. The web site will include comprehensive information on LTC, have well-developed keywords and navigation capabilities, and be linked to major search engines and other relevant web sites in a way that makes them easily accessible.

3. Establish criteria for and authorize the development of curricula for education of professionals (including doctors, nurses, pharmacists, dentists, psychologists, administrators of LTC facilities, discharge planners, social workers, and certified nursing assistants) that can be included in academic programs and continuing education requirements for licensing and/or certification and will be implemented over time.

4. Establish criteria for and authorize development of a variety of training and educational materials targeted to the specific groups described above (state employees involved in long term care, legislators and their aides, and children K-12).

Benchmarks

1. Development of campaign materials including radio and television public service announcements, print ads, brochures, and other appropriate educational materials.
2. Dissemination of campaign materials:
   a. Measured by number of media placements and numbers of materials distributed.
   b. Measured by the impact as identified by consumers, family members, and professionals that interact with the Single Point of Entry agencies.
3. Development of curricula targeted to the identified professional and educational groups.

4. Implementation of curricula targeted to the identified professional and educational groups.
5. Measured by the number of individuals that complete a curriculum or other educational program.
6. Measured by the referrals to the SPE by the professionals.
7. Measured by consumer reporting of the content of the professional interaction (i.e., if and how the professional made a referral to the SPE and whether the professional described the potential for consumer choice and control).

Recommendation # 7: Establish a New Quality Management System.

Current Issues: A quality long-term care experience is an individual evaluation. Quality is defined and measured by the person receiving supports, and not through surrogates (payers, regulators, caregivers, families, professionals and/or advocates). The elements of quality are meaningful relationships, continuity of community involvement in the person's life, personal well-being, performance measures, customer satisfaction measures, the dignity of risk taking, and the freedom to choose or refuse available options.

The task force members agree that a high quality LTC system of support and services must recognize the primacy of the consumer as center of any assessment or evaluation of the quality of the system. The consumer's needs, experiences, and satisfaction are the lenses through which any quality assurance effort must be viewed.

Oversight of the LTC system in Michigan is scattered among several state agencies. This leads to confusion in policy direction and budget development. The lack of a central point for quality management of the LTC system within the executive branch is a critical issue for consumers and policymakers alike.

Recommended Actions

Align regulations, reimbursement, and incentives to promote this vision of quality and move toward that alignment in all sectors of the LTC system. Ensure that the consumer is the focus of quality assurance system.

Strategies / Action Steps

1. Develop and implement use of consumer experience/consumer satisfaction surveys and measurements.
2. Include a strong consumer advocacy component in the new system.
3. Review and analyze current performance measures (both regulatory and non-regulatory).
4. Design performance measures that move Michigan's LTC system toward this vision of quality.
5. Invest quality management functions in a new Long-Term Care administration. The administration would improve quality by consolidating fragmented pieces of LTC, and defining and establishing broader accountability across the LTC array of services and supports. [Section 7 of the model Michigan Long-Term Care Consumer Choice and Quality Improvement Act in the appendix discusses some of the quality management functions in detail.]

Benchmarks

1. Consumer determination of quality is the priority quality measure.
2. Person-centered planning is implemented throughout the LTC system.
3. Oversight of QM is established within LTC Commission and LTC administration.

Recommendation # 8: Michigan Should Build and Sustain Culturally Competent, Highly Valued, Competitively Compensated, and Knowledgeable LTC Workforce Teams that Provide High Quality Care within a Supportive Environment and are Responsive to Consumer Needs and Choices.

Current Issues: The long-term health care sector faces systemic challenges to attract and retain a qualified workforce. While the state's elderly population is projected to expand by 52% in the next 20 years, the traditional sources of new caregivers (women aged 25 to 44) will shrink by 10%.

High vacancy and turnover rates across the long-term care sector harm consumers, providers, workers, and ultimately our communities. Training for LTC workforce, particularly direct care workers, needs improvement across the sector. The package of wages, health care coverage, paid time off, and other benefits offered LTC employees are rarely competitive. While better compensation is not the single answer to workforce needs, it is an essential element in attracting and retaining a qualified team of individuals.

Long-term care, unlike many other business sectors, creates more jobs consistently every year. Unlike other employment sectors, long-term care has some natural career paths for advancements. Despite the growing number of jobs, the state lacks basic data about the current LTC workforce and projections for future employment.

To make careers in long-term care attractive, long-term care organizations—large and small—must embrace new participatory management and delivery systems that are consumer-centered and worker-friendly.

Recommended Actions

Develop and implement strategies to attract and recruit into long-term care careers an increasing number of capable, committed, energetic individuals. Improve LTC worker job retention to relieve current and future worker shortages, reduce labor-turnover costs, and continue high quality care and supports. Ensure competitive wages/salary for LTC workers based on their level of education, experience, and responsibilities. Provide comprehensive affordable health care coverage for workers and their families. Promote adequate retirement planning for all employees. Develop and implement strategies that value contributions of the direct care worker as part of the LTC team in the provision of supports and services.

Strategies / Action Steps

1. Develop within the Michigan Works! Agencies (MWA) network, recruitment and screening protocols and campaigns that meet the needs of employers and job seekers.

2. Recast the state's Work First program to recruit, screen, train, and support individuals who demonstrate the desire, abilities, and commitment to work in LTC settings.

3. Develop recruitment campaigns to attract men, older workers, people of diverse cultural backgrounds, and people with disabilities to long-term care careers.

4. Mobilize state agencies' activities to include the research, exploration, explanation, and promotion of career opportunities in long-term care.

5. Improve and increase training opportunities for direct care workers to allow for enhanced skill development and employability.

6. Increase training opportunities for employers to improve supervision and create a positive work environment.

7. Reduce the rates of injury and exposure to hazardous materials to protect the current workforce and encourage new workers to join this workforce because of the sector's safety record.

8. Raise Medicaid reimbursement rates and other incentives so that the LTC workforce

receives compensation necessary to receive quality care as defined by the consumer.

9. Expand the ability of all long-term care employers and their employees, particularly their part-time employees, to access affordable health care coverage for themselves and their families.

   The Department of Human Services (DHS), Michigan Department of Community Health (MDCH), Michigan Office of Services to the Aging (OSA), Department of Labor and Economic Growth (DLEG) and other state agencies should work collaboratively to identify standards and benchmarks ensuring that direct care workers are key partners and team members in providing quality care and supports.

10. Develop health professional curricula and reform current practice patterns to reflect the changing needs of the population. Recognize the unique needs of the elderly; people with chronic health problems; people approaching end-of-life; people of all ages with disabilities; and those in need of rehabilitative and restorative services across LTC and acute care settings.

11. LTC administration will track employment trends, including turnover rates.

Benchmarks

1. Measurable increase in LTC employer use of MWA services and in LTC employer hiring of Work First participants.
2. More qualified Work First participants are recruited and successfully employed in the LTC industry, while continuing their education for entry into licensed occupations.
3. Higher compensation packages and increased training opportunities.
4. Continuously and incrementally reduced turnover rates over the next decade.
5. All people working in LTC have access to affordable health care coverage.
6. Increased use of creative management and workplace practices.
7. Use of data and consumer satisfaction to inform a system of services, state policies, and employer practices that result in consumer-driven outcomes.
8. Increased opportunities and incentives for LTC employers and their supervisory personnel to improve supervisory and leadership skills to create positive workplace environments and relationships to reduce turnover.

Recommendation # 9: Adapt Financing Structures that Maximize Resources, Promote Consumer Incentives, and Decrease Fraud.

Current Issues: The task force bases its recommendations on these general funding assumptions:

1. Current resources are not sufficient to adequately fund needed supports and services.
2. The demand for long-term care supports and services will continue to increase as the population ages and as longevity increases.
3. Medicaid dollars available to meet anticipated demands are already being fully utilized within the state of Michigan, and federal support for future increases does not appear likely. While some efficiencies and cost savings of Medicaid dollars may be realized as part of the process of this review of the long-term care system, these dollars should not be expected to be sufficient to resolve existing financial shortages.
4. State legislative leaders and state policy makers must assure that non-Medicaid resources currently available to the state continue to be used to offer long-term care services and supports for Medicaid and non-Medicaid eligible individuals. This principle should reflect the need to maximize the availability and the flexibility of all funding sources in providing access to long-term care services and supports for residents of the state.

5. Leaders of the state's executive and legislative branches must acknowledge that while long-term care supports and services for the state's population must be adequately funded, this should not occur at the expense of, or detriment to, other vital state services such as public safety, public education, and the general public welfare. It is further incumbent upon the state's leadership and decision-makers to avoid the "pitting" of those in need of long-term care supports and services against the need for other public services in the allocation of currently scarce public resources.
6. The state must make a commitment to reinvesting all dollars realized from cost savings identified within the long-term care system back into long-term care supports and services. As changes to the system are recommended it is critical that any identified savings are not viewed as a way to help balance the state budget during a difficult economic period, but rather as a way to assure that an adequate system of long-term care supports and services is available to residents of the state of Michigan.

Recommended Actions

Leaders of the state's executive and legislative branches must make a commitment to take necessary actions to adequately fund long-term care supports and services for residents of Michigan. Decisions for adequate funding of long-term care services should be based upon identified needs and not be made at the expense of other vital publicly funded state services.

Strategies /Action Steps

1. Michigan should decouple its estate tax from the federal estate tax to make more revenue available.
2. Michigan should identify sources of non-federal tax revenue that are utilized to provide LTC and support services for Medicaid consumers, and create policies and procedures that will allow these funds to be used as local match to capture additional federal Medicaid dollars for long-term care and supports.
3. The Michigan Congressional Delegation should:
    a. Advocate for the removal of the congressional barrier imposed on the development of Partnership program by states between Medicaid and long-term care insurance.
    b. Strongly advocate that the federal government assume full responsibility for the health care needs of individuals who are dually eligible for Medicare and Medicaid.
    c. Urge the Congress to revise the current Federal Medical Assistance Percentage (FMAP) formula to a more just methodology using Total Taxable Resources or a similarly broader measure and to shorten the time frame from the data reporting period to the year of application.
4. Subject to appropriate reviews for actuarial soundness, overall state budget neutrality, and federal approvals, Michigan should establish a mandatory estate preservation program instead of establishing a traditional Medicaid Estate Recovery Program.
5. Legislation that promotes the purchase and retention of long-term care insurance policies and that addresses ratemaking requirements, insurance standards, consumer protections, and incentives for individuals and employers should be drafted, reviewed, introduced, and enacted after review by a representative group of consumers, advocates, and providers.
6. Three specific strategies aimed at increasing the number of people in Michigan who have long-term care insurance should be implemented: a) gain federal approval for the use of the Long-Term Care Insurance Partnership Programs.; b) expand the state employees' self-funded, long-term care insurance program; and c) examine the possibility of a state income tax credit for purchase and retention of long-term care insurance.
7. Tax credits and tax deductions for the purchase of long-term care insurance

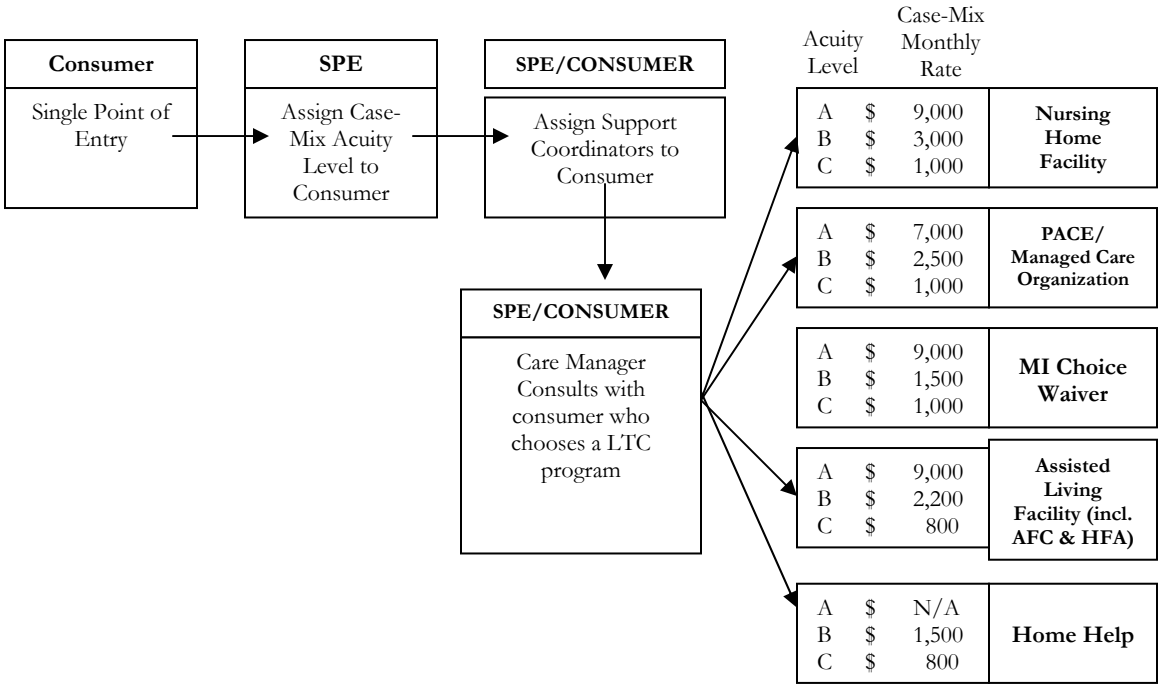
policies and for "out of pocket costs" for LTC should be considered.

8. A "special tax exemption" for taxpayers who provide primary care for an eligible parent or grandparent (and possibly others) should be explored. Based upon a $1,800 exemption proposed in legislation introduced in 2005, the Senate Fiscal Agency estimates cost to the state in reduced revenue at less than $1 million.

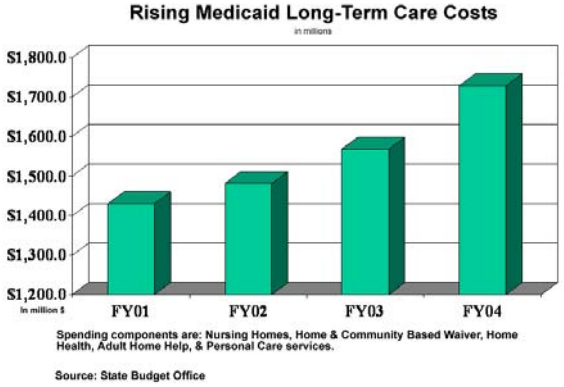
As an initial step, Michigan should adopt a Case-Mix reimbursement system to fund LTC services and supports. This approach sets provider rates according to the acuity mix of the consumers served. The higher the acuity, the higher the rate paid to the provider due to the resources needed to care for the consumers. As the long-term care system evolves, other appropriate funding mechanisms should also be considered and adopted.

Below is a chart that illustrates how such a Case-Mix system would be operationalized. These are examples and not proposed rates, offered for the purpose of illustrating how a case-mix reimbursement might work.

Case Mix Reimbursement Flow Chart



9. Michigan should encourage and strengthen local and regional programs that support caregivers in their care giving efforts.
10. An ongoing and centralized data collection process by DHS of trusts and annuities information should continue to be used to guide the need for state regulation.
11. There should be ongoing review and strengthening, along with strict and consistent enforcement, of laws and regulations governing the inappropriate use of trusts and annuities for Medicaid eligibility.
12. There must be more frequent, vigorous, and publicized prosecution of those who financially exploit vulnerable individuals.
13. State agencies should cooperate in discovering and combating Medicaid fraud, and recovering funds paid for inadequate care.
14. New legislation for the regulation by the state of "trust mills" and annuity companies should be enacted. This legislation should address the prevention of abusive sales tactics through the implementation of insurance industry regulations, registration of out-of-state companies, and prescreening of sales materials.
15. Appropriate state agencies should analyze and quantify the relationship between public and private resources, including both time and money, spent on LTC. This analysis should be used as a way to obtain a match for federal Medicaid dollars.
16. The state should study and pursue aggressive Medicare recovery efforts.
17. Medicaid eligibility policies should be amended to:
    a. Permit use of patient pay amounts for past medical bills, including past nursing facility bills.
    b. Require full certification of all Medicaid nursing facilities.
    c. Require dual certification of all nursing facilities.
18. The task force recommends full funding for an external advocacy agency on behalf of consumers accessing the array of supports and services overseen by the SPE system. Based on a conservative figure, the total budget line for this item would be $4.3 million. Of the increase, $2 million would be to bring the State Long-Term Care Ombudsman program into compliance with national recommendations; $2.3 million would go to the external advocacy organization outlined in Section 8 of the Model Act.



Benchmarks

1. Increased state and federal support will be available to implement Person-Centered Plans and consumer choice options.
2. A reduction of inappropriate asset and income sheltering will be achieved.
3. Improved federal-state funding partnership will be achieved.
4. An increase in the number of Michigan citizens with LTC insurance will be achieved.
5. An adequate allocation of finances and resources across the array of supports and services will reflect informed consumer choices in the delivery of LTC services and supports.

Time Frames

Vision Statement: Within the next ten years, Michigan will achieve a high quality, easily accessible system of publicly and privately funded long-term care supports. These supports will include a full array of coordinated services available wherever an individual chooses to live and will be mobilized to meet the needs of each person with a disability or chronic condition, of any age, who needs and wishes to access them.

The arrangement and type of care and supports for each person will be determined by that person. Person-centered planning, which places the person as the central focus of supports and care planning, will be used to determine all facets of care and supports plans. Each person, and his or her chosen family, friends, or professionals, will initiate or re-start the process whenever the person's needs or preferences change. Selected milestones in reaching this objective include:

1. By January 1, 2006, the Department of Community Health will establish a person-centered planning protocol specific to long-term care consumers.
2. By October 1, 2006, every entity providing LTC services will have person-centered planning policies and training in place.
3. Phased-in implementation of the Single Point of Entry system will begin in 2005 with at least three sites launched before the end of 2006.
4. By the end of three years (2009), the SPE system will be operating throughout the whole state. The public awareness and education campaign will correspond with the launching of the SPE for each region, so that consumers can both gain awareness and find answers to their questions about LTC.
5. Effective October 1, 2005 and quarterly thereafter, MI Choice waiver program enrollment and funding will be incrementally increased to meet demand for MI Choice services to eliminate the need for waiting lists.
6. In the summer 2005, MDCH will seek approval from the federal government to amend the MI Choice waiver to allow for provision of its services in licensed assisted living settings.
7. By fall of 2005, introduce legislation to create the Long-Term Care Commission.
8. By the end of summer 2005, the Long-Term Care Administration (LTCA) will be created as part of MDCH and begin its quality management functions.
9. By the beginning of calendar year 2006, the LTCA (or MDCH) will begin to work with other state agencies to coordinate LTC workplace issues and conduct training.
10. Beginning with the 2006 fiscal year, Michigan Medicaid will begin the process of converting to a Case-Mix reimbursement system to fund LTC services and supports.
11. Beginning with 2006 and continuing over the following three years, develop health professional curricula, and reform current practice patterns.

Recommendations for Further Study

The task force identified a number of issues that deserve greater attention than it was able to give them in its limited time. These include:

1. Examination of the Certificate of Need (CON) issues related to the supply of nursing facility beds.
2. Further exploration of managed care and other financial options as alternatives to the present system and the proposed case mix reimbursement system.
3. Eligibility inequities among the various programs.
4. Credentialing of consumer advocates.
5. Study of unlicensed assisted living services to determine if appropriate consumer protections are in place and enforced.
6. Budgeting and funding of outreach efforts, such as the public education campaign.
7. Study of reverse equity mortgages as a potential source of funding to allow individuals to age in place.
8. Study how the task force recommendations interact with other LTC systems.

Conclusion

Michigan's Long-Term Care system, increasingly supported and influenced by Medicaid, has the long overdue need to link its many separate specialized programs into an array of services and supports for the state's consumers of LTC. The state's lack of a consistently articulated and implemented long-term care strategy has hindered the efforts of consumers and their families to make sense of the chaos. As the task force repeatedly heard in public comment, many consumers are unhappy with the experience in the long-term care system, and often feel that they have no recourse. Ongoing demographic, legal, and economic pressures will only make this situation worse unless the state adopts a new strategy to confront the systemic problems.

Principles such as "person-centered planning" and "money follows the person" must guide the administration of current programs and the development of new ones. Mechanisms to give dignity, control, and flexibility flow out of these principles. Barriers such as mixed eligibility criteria, quotas, and insufficient funding impede them. Consumers need to be educated about the available options, and be provided incentives, such as tax benefits for the purchase of LTC insurance, to personally prepare in advance for them. Strong prevention and caregiver support programs will lessen the need for entry into LTC programs, and organizational structures such as the Single Point of Entry (SPE) will help consumers once the need arises. Additional structures such as the Long-Term Care Commission will ensure that consumers and other interested parties stay engaged in the development and oversight process. A Long-Term Care Administration will centralize the state's efforts to conduct LTC policy and implementation, while monitoring and enforcing high quality standards.

However, LTC programs cannot adequately function without a highly qualified, fairly compensated and culturally diverse workforce. The shortage of personnel across the spectrum, from direct care workers to skilled SPE facilitators, will continue to hinder quality service delivery unless it is addressed. Although some financial "savings" may result from greater efficiency and the development of cost-effective alternatives to institutional care, the LTC system will continue to require a steady and strong commitment of support and resources from the legislature and governor's office to function. The aging of the population, if nothing else, will continue to pressure the system and keep LTC at the forefront of the state policy agenda. The need for fundamental change is upon the state now.

Michigan's current long-term care system is not sustainable. The barriers to progress can be challenged and overcome. The Michigan Medicaid Long-Term Care Task Force, consisting of a diverse group of people, struggled with many issues and developed the proposals shown above. It is now up to administrators, legislators, and people of goodwill at all levels to work collaboratively toward solutions designed to be effective and sustainable. Failure is not an option.

Appendices

Task Force Members

Wardeh (Rose) Alcodray-Khalifa, Oakwood Healthcare, Inc. and the Amer-Arab Nurse Association

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- Branch-St. Joseph AAA
- Burnham Brook Region (3B)
- Region 4 AAA
- AAA of West Michigan
- Region 3C-AAA
- Detroit Area Agency on Aging
- Northeastern Michigan Community Service Agency
- Tri County Office on Aging
- UP AAA/UPCAP

A & D Home Health Care
AARP/Michigan
ACA & Association for Retarded Citizens
Adult Well-being Services
Alzheimer's Association
American Association of Retired Persons
American House Senior Living Residences
Autism Society of Michigan
ARC of Michigan
Beier Howlett, PC
Blue Cross Blue Shield of Michigan
Bringing the Eden Alternative to the Mid-West
Capitol Area Center for Independent Living
Capitol Services, Inc
Caring Hearts Home Care
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Community Operations for AARP of Michigan
Complete Compassionate Care
Council of Michigan Foundations
County Medical Care Council
Department of Human Services
Department of Labor and Economic Growth
Detroit Community Health Connection
Developmental Disabilities Council
DYNS Services, Inc
ELAS Council
Elder Law of Michigan
Elder Law Section, State Bar of Michigan
Greater Grace Temple
Health Care Association of Michigan
Heritage Community of Kalamazoo
HHS Health Options
Huntington's Disease Society of America, Michigan Chapter
Lakeland Home Health Assn.
Lansing Community College
Lenawee County Medical Care Facility
Lutheran Home Care Agency/Hospice of Hope
Lutheran Social Services of Michigan
Macomb County Senior Citizens Services
Macomb-Oakland Regional Center
Michigan Department of Community Health
Office of Services to the Aging
Medical Services Administration
Michigan Home Health Association
Michigan Assisted Living Association
Michigan Association of Centers for Independent Living
Michigan Association of Homes and Services for the Aging
Michigan County Medical Care Facilities Council

Michigan County Social Services Association
Michigan Disability Rights Coalition
Michigan Home Health Association
Michigan House of Representatives
Michigan Poverty Law Program
Michigan Protection and Advocacy Service
Michigan Senate
Michigan State University
Michigan State University/Institute for Health Care Studies
Mid-Michigan Visiting Nurses
Miller Johnson Snell & Cumminskey, PLC
Monroe County Commission on Aging
New York Life Insurance Company
Oakwood Healthcare
Operation ABLE
Paraprofessional Healthcare Institute
Pilgrim Manor Retirement Community
Pinecrest Medical Care Facility
Pine Rest Christian Mental Health Services
Presbyterian Village of Michigan
Senior Services Kalamazoo
Service Employees International Union
South Central Michigan Works!
State Budget Office
State Library of Michigan
State LTC Ombudsman Program
Sunset Association
Sutton Advisors
The Ashland Group
The Disability Network
The Howell Group
United Cerebral Palsy of Michigan
University of Michigan School of Nursing
University of Michigan/Institute of Gerontology
Visiting Physician Services
Washtenaw Association of Community Advocacy
Wayne State University/Institute of Gerontology
White Nursing and Rehabilitation Center

Glossary

Array of Services and Supports	Also referred to as a "continuum of care" and an "integrated system of care." An accessible, coordinated service system that assures those in need of services and supports have available a broad range of options that allows them to live and receive LTC services and supports where they choose.
Assisted Living	Assisted living is a marketing term often used by: 1.) state licensed adult foster care homes (as defined in MCL 400.703 through 400.407); 2.) state licensed homes for the aged (as defined in MCL 333.20106(3)); 3.) unlicensed settings, including housing with services contract establishment; and other supported independent living arrangements.
Case Mix Adjustment/Reimbursement	(Also known as acuity-based reimbursement) Under this strategy, payments are adjusted to reflect the actual (or expected) mix of care provided and the health status of patients treated. This is often combined with techniques that prospectively define reimbursement rates for various services or treatment of specific types of conditions (diagnosis-related groups). Many states use case mix reimbursement systems for nursing facilities. (Source: National Conference of State Legislatures at http://www.ncsl.org/programs/health/forum/cost/strat7.htm) (Also known as acuity-based reimbursement).
Consumer-Directed Care	Consumer directed care integrates and maximizes consumer choice and control into all aspects of home and community-based care. One of the most critical tenets of consumer direction is the belief that individuals have the primary authority to make choices that work best for them regardless of their age or disability. Choice and control are key elements of consumer-directed care.
Home and Community-Based Services	Home and community-based services are long-term support services for people who need assistance with activities of daily living (ADLs), such as eating, bathing and dressing, or instrumental activities of daily living (IADLs), such as preparing a meal or managing medications, in order to live at home or in the community. They may, depending on the program, include any of the following types of services. • Personal care, homemaker, and chore assistance. • Adult day programs that provide therapeutic activities, meals, and transportation. • Respite care or substitute care during the day and on weekends, evenings, and emergencies, or as short stays in long-term care facilities, to provide relief to the family caregiver.

	• Home modifications and personal care supplies. • Services in residential care facilities, including assisted living, foster care, and board and care homes. • Care planning and case management, including a comprehensive assessment by a case manager and the network of professionals and programs appropriate for providing care. • Vocational services, including supported employment programs, vocational evaluations, job training and placement, and work adjustment programs. • Other quality of life services, such as recreation and leisure activities, transportation, and early intervention programs. (Source: National Conference of State Legislatures at http://www.ncsl.org/programs/health/forum/cost/strat7.htm)
Long-Term Care Insurance	An insurance policy to cover the cost of long-term custodial care in a nursing facility or at home. (Source: State of Michigan Department of Labor and Economic Growth)
Long-Term Care Workforce	Paid and unpaid individuals and agencies that provide direct care and/or supportive services across the continuum.
Money Follows the Person	"Money follows the person" refers to a system of flexible financing for long-term services that enables available funds to move with the individual to the most appropriate and preferred setting as the individual's needs and preferences change. To the individual, the movement of these funds may appear seamless. People receiving supports, not providers or program managers, drive resource allocation decisions as they move through the long-term care system. (Source "Money Follows the Person and Balancing Long-Term Care Systems: State Examples," CMS, currently available at: http://www.cms.hhs.gov/promisingpractices/mfp92903.pdf)
Nursing Facility	A licensed institution primarily engaged in providing to residents: • Skilled nursing care and related services for residents who require medical or nursing care • Rehabilitative services for the rehabilitation of injured, disabled, or sick persons, and • On a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board), which can be made available to them only through institutional facilities. • Source: Social Security Act 1919b, 42 U.S.C. §1396r
Person-Centered Planning	"Person-centered planning" means a process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote

	community life and that honors the individual's preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals as the individual desires or requires. Source: Michigan Mental Health Code, MCLA 330.1700 (g)
Person-Centered Planning Facilitator	A person-centered planning facilitator is an individual who has been chosen by the person to assist them and their invited guests through the person-centered planning process. In some cases, the consumer may choose to act as their own person-centered planning facilitator. The facilitator should guide the person and their team through the development of an action plan. He/she should take on an active role promoting the person, reframing behavior as communication, identifying barriers, and encouraging the full and meaningful participation of each guest. (Source: Presentation to the Long-Term Care Task Force by Dr. Sally Burton Hoyle, Autism Society of Michigan.)
Single Point of Entry	"Single Point of Entry" agencies will provide information, referral, and assistance to individuals seeking services and supports for long term care. Assistance will include case and supports coordination, authorizing (but not providing) Medicaid services. They also will serve as a resource on long-term care for the community at large and caregivers. Use of the SPE agency is mandatory for individuals seeking to access publicly funded programs.

Model Act

MICHIGAN LONG-TERM CARE CONSUMER CHOICE
AND QUALITY IMPROVEMENT ACT

FEBRUARY 14, 2005

Sec. 1 Short title

This act shall be known and may be cited as the "Michigan Long-Term Care Consumer Choice and Quality Improvement Act."

Sec. 2 Definitions

1) Definitions: When used in this Act, the following words shall have the following meanings:

(a) "Authority" means the entity created pursuant to section 4 of this act.

(b) "Commission" means the long-term care commission established pursuant to section 3 of this act.

(c) "Consumer" means an individual seeking or receiving public assistance for long-term care.

(d) "Department" means the department of community health.

(e) "Director" means the director of the department.

(f) "Long-term care" means those services and supports provided to an individual in a setting of his or her choice that are evaluative, preventive, habilitative, rehabilitative or health related in nature.

(g) "Medicaid" means the program for medical assistance established under title XIX of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1396 to 1396f, 1396g-1 to 1396r-6, and 1396r-8 to 1396v, and administered by the department under the social welfare act, 1939 PA 280, MCL 400.1 to 400.119b.

(h) "Person-centered planning" means a process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and that honors the individual's preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals as the individual desires or requires.

(i) "Primary consumer" means the actual user of long-term care services.

(j) "Secondary consumer" means family members or unpaid caregivers of consumers.

(k) "Single points of entry" means those entities created pursuant to section 6 of this act.

(l)"Transition services" means those services provided to assist an individual in moving from one setting to another setting of his or her choice and may include, but is not limited to, the

payment of security deposits, moving expenses, purchase of essential furnishings, and purchase of durable medical equipment.

Sec. 3 Findings and purpose

1) The legislature finds that long-term care services and supports are critically important for Michigan citizens, their families, caregivers and communities, that the need for long-term care services and supports is expected to increase substantially as the number of older people and people with disabilities increases, that consumers will be best served by the creation and continuing refinement of a carefully coordinated long-term care system that promotes healthy aging, consumer education and choice, innovation, quality, dignity, autonomy, the efficient and effective allocation of resources in response to consumer needs and preferences, and the opportunity for all long-term care consumers, regardless of their age or source of payment, to develop and maintain their fullest human potential.

2) Consistent with section 51 of article IV of the state constitution of 1963, which declares that the health of the people of the state is a matter of primary public concern, and as required by section 8 of article VII of the state constitution of 1963, which declares that services for the care, treatment, education or rehabilitation of persons with disabilities shall always be fostered and supported, the department is charged with the primary responsibility for ensuring the development and availability of a system of long-term care as described in this act.

3) The purpose of this Act is to ensure all of the following:

(a) That consumers have access to a well-coordinated, comprehensive, adequately funded and dynamic array of long-term services and supports including but not limited to assessment, care planning, in-home services and supports, a range of assisted living options, care management services, respite care services, nursing facility care, hospice care, primary care, chronic care management, supports coordination, and acute care. This array of services and supports must be designed through a person-centered planning process to meet existing consumer needs and preferences, be flexible and responsive to changing consumer needs and preferences, and encourage innovation and quality;

(b) That consumers are provided with sufficient education and support to make informed choices about their long-term care service and supports options;

(c) That the system is consumer focused, embraces person centered planning, and fosters the creation of innovative long-term care options;

(d) That services and supports are provided in the most independent living setting be consistent with the consumer's needs and preferences;

(e) That access to long-term care services and supports is determined by a uniform system for comprehensively assessing abilities and needs;

(f) That public resources purchase, permit, and promote high quality settings, services, and supports through:

(1) adequate and consistent monitoring of publicly funded settings, services and supports;
(2) consistent and appropriate enforcement of statutory and regulatory standards;
(3) monitoring of outcomes of long-term care for quality and adherence to the consumers' expressed preferences; and

(4) swift and effective remedies if services, supports, or settings fail to meet quality standards or to promote long-term care consumers' dignity, autonomy, and choice.

(g) The goal of the system shall be continuous quality improvement focused on consumer satisfaction and the consistent achievement of clear standards concerning the health, safety, autonomy, and dignity of long-term care managers; family members; and others when appropriate. These mechanisms shall assist regulators and policy makers in evaluating quality and consumer satisfaction and in determining necessary adaptations and improvements in the dynamic long-term care system.

(h) That long-term care services are coordinated in a way that minimizes administrative cost, eliminates unnecessarily complex organization, minimizes program and service duplication, and maximizes the use of financial resources in meeting the needs and preferences of long-term care consumers.

(i) That the state collects, analyzes, and distributes to the public on an ongoing basis complete data regarding current utilization of long-term care services and supports, unmet needs, consumer preferences, demographic data, workforce capacity, and other information that will assist the state in the continuing coordination and refinement of its long-term care system. In addition, ensure the state publishes periodic reports that assess the adequacy and efficacy of the reimbursement and enforcement systems and identify areas requiring improvement, unmet needs, successful innovations, and best practices.

(j) That state and the long-term care industry build and sustain an adequate, well-trained, highly motivated and appropriately compensated workforce across the long-term care continuum.

(k) That all stakeholders including consumers and their families and advocates, providers, representatives of the long-term care workforce, public officials and others have a continuing opportunity for meaningful input in the development and refinement of the long-term care system.

Sec. 4 Long-term care commission

1) A commission on long-term care is hereby established, to be appointed by the governor.

2) The commission shall consist of twenty-five members appointed by the governor. Commission membership shall consist of fourteen consumers, of which at least fifty percent are primary consumers and of those primary consumers at least fifty percent shall be users of Medicaid services, the remainder comprised of secondary consumers and consumer organization representatives, seven providers or provider organization representatives, three direct care workers and one member with expertise in long-term care research from a university. Overall commission membership shall also reflect the geographic and cultural diversity of the state.

3) One representative each from the single point entry network, the State Long-Term Care Ombudsman, the designated protection and advocacy system, the Department of Community Health, the Department of Human Services and the Department of Labor and Economic Growth, all of whom shall serve in non-voting supporting roles as ex-officio members. Staff from the Medical Services Administration and the Office of Services to the Aging shall serve as resources to the commission and shall assist the commission as needed.

4) Voting member terms shall be three years, staggered to ensure continuity and renewable under the appointment process. If a vacancy occurs during the term of a voting member, the governor shall appoint a replacement to serve out the remainder of the term and shall maintain the same composition for the commission as set forth in sec. 4(2).

5) Commissioners are entitled to receive a stipend, if not otherwise compensated and reimbursement for actual and necessary expenses while acting as an official representative of the commission as defined by commission policies and procedures. Commission policies and reimbursement shall establish and practice full accommodation to individual support needs of commission members, including their direct care and support workers or personal assistants, support facilitation or other persons serving them as secondary consumers.

6) The governor shall designate one person from among the consumer membership to serve as chairperson of the commission, who shall serve at the pleasure of the governor.

7) The commission shall do all of the following:

(a) Serve as an effective and visible advocate for all consumers of long-term care supports and services.

(b) Participate in the preparation and review, prior to the submission to the governor, of an ongoing, comprehensive statewide plan and budget for long-term care services and supports design, allocations and strategies to address and meet identified consumer preferences and needs.

(c) Ensure the broadest possible ongoing public participation in statewide planning as part of subsection (1)(b).

(d) Ensure broad, culturally competent, and effective public education initiatives are ongoing on long-term care issues, choices and opportunities for direct involvement by the public.

(e) Evaluate the performance of the designated single point of entry agencies on an annual basis and make its report and recommendations for improvement to the single point of entry system available to the legislature and the public.

(f) Continuously monitor spending and budget implementation, including how well expenditures match policy decisions and initiatives based on consumer preferences and needs.

(g) Meet at least six times per year.

(h) A quorum of the commission shall consist of at least fifty percent of the voting membership, provided at least eight consumer members are present or participating. Participation may be by telephone or other means, in accordance with other statutory provisions and as determined by the commission.

Sec. 5 Long-term care administration

1) (Insert here language directing how the administration will be created, where it will be located, etc.).

2) The long-term care administration shall do all of the following:

(a) Serve as an effective, visible, and accessible advocate for all consumers of long- term care supports and services.

(b) Prepare and implement an ongoing, comprehensive statewide plan for the governor for long-term care services and supports design, administration and oversight to ensure delivery of an organized system which meets identified consumer preferences and needs.

(c) Develop and implement an ongoing budget that ensures state financial resources follow consumer preferences under the comprehensive state plan for review by the commission prior to submission to the governor.

(d) Ensure the broadest possible ongoing public participation in statewide planning as part of subsection (2)(b).

(e) Recommend to the department director designations and de-designations of the state's single points of entry (SPE) network agencies under established guidelines; recommend contract awards; establish performance and review standards for SPE agencies; receive standardized annual and other reporting from the agencies.

(f) Ensure broad, culturally competent and effective public education initiatives are ongoing on long-term care issues and choices.

(g) Advise the governor, the legislature, and directors of relevant agencies and department heads regarding changes in federal and state programs, statutes, and policies.

(j) As part of its ongoing planning, identify and address long-term care workforce capacity, training and regulatory issues in both the public and private sectors.

(k) Retain state approval over proposed changes in Medicaid policy and services related to long-term care before publication and comment; continually reform eligibility policy to improve timeliness and access.

(l) Develop and maintain a comprehensive state database and information collection system on long-term care service and supports capacities and utilization that is publicly accessible, while protecting individual consumer privacy, for the purposes of individual and state-aggregated planning, forecasting, and research.

(m) Ensure all necessary and vital linkages among acute, primary and chronic care management supports and services are maintained and continually strengthened to complement, leverage, and enhance services, supports and choices in the long-term care system.

(n) Develop and implement policies and procedures that will facilitate efficient and timely transition services for individuals moving from a nursing facility to home or apartment in the community. Services may include, but are not limited to payment of security deposits, moving expenses purchase of essential furnishings and durable medical equipment.

(o) Identify and implement progressive management models, culture change, and indicated administrative restructuring to maximize efficiency, optimize program design and services delivery; provide technical assistance in these areas to providers and interested members of the public.

(p) Establish a comprehensive, uniform, and enforceable consumer rights and appeals system.

Sec. 6 Single points of entry

1) It is the intent of the legislature that locally or regionally based single points of entry for long-term care serve as visible and effective access points for persons seeking long-term care and promote consumer education and choice of long-term care options.

2) The director shall designate and maintain locally and regionally based single points of entry for long-term care that will serve as visible and effective access points for persons seeking long-term care and promote consumer choice.

3) The department shall monitor designated single points of entry for long-term care to:

(a) prevent bias in eligibility determination and the promotion of specific services to the detriment of consumer choice and control;

(b) Review all consumer assessments and care plans to ensure consistency, quality and adherence to the principles of person-centered planning and other criteria established by the department;

(c) Assure the provision of quality assistance and supports;

(d) Assure that quality assistance and supports are provided to applicants and consumers in a manner consistent with their cultural norms, language of preference, and means of communication.

(e) Assure consumer access to an independent consumer advocate.

4) The department shall establish and publicize a toll-free telephone number for those areas of the state in which a single point of entry is operational as a means of access to the single point of entry for consumers and others.

5) The department shall promulgate rules establishing standards of reasonable promptness for the delivery of single point of entry services and for long-term care services and supports.

6) The department shall require that designated single points of entry for long-term care perform the following duties and responsibilities:

(a) Provide consumers and any others with information on and referral to any and all long-term care options, services, and supports;

(b) Facilitate movement between supports, services, and settings in an adequate and timely manner that assures the safety and well-being of the consumer;

(c) Assess a consumer’s eligibility for all Medicaid long-term care programs utilizing a comprehensive level of care tool;

(d) Assist consumers to obtain a financial determination of eligibility for publicly funded long-term care programs;

(e) Assist consumers to develop their long-term care support plans through a person-centered planning process;

(f) Authorize and, if requested, arrange for needed transition services for consumers living in nursing facilities;

(g) Work with consumers in acute and primary care settings as well as community settings to assure that they are presented with the full array of long-term care options;

(h) Re-evaluate consumers' need and eligibility for long-term care services on a regular basis;

(i) Perform the authorization of Medicaid services identified in the consumer's care supports plan.

7) The department shall, in consultation with consumers, stakeholders, and members of the public, establish criteria for the designation of local or regional single points of entry for long-term care. The criteria shall assure that single points of entry for long-term care:

(a) Are not a provider of direct Medicaid services. For purpose of this act, care management and supports coordination are not defined as a direct Medicaid service;

(b) Are free from all legal and financial conflicts of interest with providers of Medicaid services;

(c) Are capable of serving as the focal point for all persons seeking information about long-term care in their region, including those who will pay privately for services;

(d) Are capable of performing consumer data collection, management, and reporting in compliance with state requirements;

(e) Have quality assurance standards and procedures that measure consumer satisfaction, monitor consumer outcomes, and trigger care and supports plan changes;

(f) Maintain internal and external appeals processes that provide for a review of individual decisions;

(g) Complete an initial evaluation of applicants for long-term care within two business days after contact by the individual or his or her legal representative; and

(h) In partnership with the consumer, develop a preliminary person-centered plan within seven days after the applicant is found eligible for services.

8) Designated single points of access for long-term care that fail to meet the above criteria, and other fiscal and performance standards as determined by the department, may be subject to de-designation by the department.

9) The department shall promulgate rules establishing timelines of within two business days or less for the completion of initial evaluations of individuals in urgent or emergent situations and shall by rule establish timelines for the completion of a final evaluation and assessment for all individuals, provided such timeline is not longer than two weeks from time of first contact.

10) The department shall solicit proposals from entities seeking designation as a single point of entry and shall designate at least three agencies to serve as a single point of entry in at least three separate areas of the state. There shall be no more than one single point of entry in each designated region. The designated agencies shall serve in that capacity for an initial period of three years, subject to the provisions of Sec. 4(3).

11) The department shall evaluate the performance of the designated agencies on an annual basis and shall make its report and recommendations for improvement to the single point of entry system available to the legislature and the public.

12) No later than October 1, 2008, the department shall have a designated agency to serve as a single point of entry in each region of the state. Nothing in this section shall be construed to prohibit the department from designating single points of entry throughout the entire state prior to said date.

13) The department shall promulgate rules to implement this act within six months of enactment.

Sec. 7 Quality

1) The authority shall have a continuing responsibility to monitor state agencies' performance in responding to, investigating, and ensuring appropriate outcomes to complaints and in performing its survey and enforcement functions. The Long-Term Care Administration shall issue regulations and policy bulletins, as appropriate, and take other appropriate action to improve performance or address serious deficiencies in state agencies' practices with regard to handling complaints and in performing survey and enforcement functions.

2) The authority shall establish a single toll free hotline to receive complaints from recipients of all Medicaid funded long-term care services and settings. State employees responsible for this function shall:

(a) Staff the complaint line 24 hours a day, 7 days per week;

(b) Be trained and certified in information and referral skills***;***

(c) Conduct a brief intake;

(d) Provide information and referral services to callers including information about relevant advocacy organizations; and

(e) Route the call to the appropriate state agency or advocacy organization to record and respond to the consumer's concern. Relevant state agencies shall ensure on-call staff is available after hours to respond to any calls that are of an emergency nature. The authority shall ensure that hotline staff are consistently informed how to contact on-call staff at all relevant state agencies to which long-term care complaints may be referred.

3) The administration shall also ensure that consumers can file complaints about any Medicaid funded long-term care setting or service using a simple, web-based complaint form.

4) The administration shall publicize the availability of the 24 hour hotline and web-based complaint system through appropriate public education efforts.

5) The administration shall form a workgroup to determine if state agencies' complaint protocols ensure a timely and complete response and to monitor for appropriate outcomes. The workgroup

shall also address whether state agencies are performing their survey and enforcement functions in the most effective manner and if their practices promote quality and person-centered planning.

(a) The workgroup shall be comprised of a minimum of fifty percent consumers and/or consumer advocacy groups. The remainder of the workgroup shall include the State Long-Term Care Ombudsman and/or his/her representative, long-term care providers, a representative from the designated protection and advocacy system, and representatives from the departments that enforce the regulations in long-term care facilities.

(b) The workgroup will be charged with examining the number of consumer complaints received, the timeliness of response to these complaints, the process used by state investigators for these complaints, and the resolutions of these concerns. The workgroup will utilize existing resources such as Auditor General reports on state agencies that regulate long-term care facilities or services and any additional data it requires to perform its duties. Based on these findings, the workgroup will issue recommendations to the administration and to the director.

(c) The workgroup shall also be charged with a comprehensive review of state law and policy, including licensing laws and regulations, receivership provisions, and other mechanisms for regulating long-term care services to determine whether these laws and policies should be deleted, amended, or modified to promote quality, efficiency, and person-centered planning or to reflect changes in the long term care system. The workgroup shall issue recommendations to the authority and to the director.

6) The departments responsible for licensing of long-term care settings shall, within twelve months of the date of enactment of this statute, promulgate rules to establish a process for identifying all licensed long-term care settings which, absent intervention by the state, are likely to either close or in which care is likely to diminish or remain below acceptable standards. In promulgating these rules, the departments shall consider, but not be limited to, the facility's financial stability, administrative capability, physical plant, and regulatory history.

7) If a department has a reasonable suspicion that a licensed facility lacks administrative capability, financial stability, financial capability, or is not structurally sound, it shall have the right to request any and all relevant documentation including, but not limited to, independent audits of the facility, credit reports, physical plant inspections by appropriate professionals, and other relevant information. It may also investigate and consider factors such as whether the facility has filed for bankruptcy or whether foreclosure has been filed, consistently declining occupancy rates, chronic noncompliance, or other relevant information.

8) In the event a department identifies a facility to be nonviable, it shall take appropriate measures to protect the health and safety of the residents, which may include the following:

(a) The prompt appointment of a temporary manager or receiver with authority to take all actions necessary for the purpose of stabilizing the facility and protecting the residents, including:

1. Making all improvements necessary to ensure residents receive services that meet or exceed minimum regulatory standards; or

2. If necessary and appropriate, arranging for the safe and orderly transfer of residents out of the facility consistent with their person-centered plan and choices.

(b) Redistributing beds within the community to other facilities or making funding available in other long-term care settings, including home and community based care.

9)The State shall ensure that relevant state agencies have sufficient staff to meet all statutory or regulatory time frames for the completion of their responsibilities; effectively and expediently monitor services, supports, and facilities; respond to complaints; and enforce existing state laws and regulations regarding minimum standards for long-term care services, supports, and facilities.

Sec. 8 Consumer advocate

1) No later than six months after the enactment of this act, the governor shall designate an agency with the independence and capacity to serve as an advocate for long-term care consumers, as set forth in this section. This designation shall continue indefinitely unless, for good cause shown, the agency is unwilling or incapable of performing its duties as set forth in this section.

2) The designated agency shall have the responsibility to identify, investigate, and resolve complaints concerning services provided pursuant to this act; shall assist applicants for long-term care who have been denied services and supports; and shall pursue legal, administrative and other remedies at the individual and systemic level to ensure the protection of and advocacy for the rights of long-term care consumers.

3) The designated agency shall have access at reasonable times to any consumer in a location in which services and supports are provided.

4) The designated agency shall have access to the medical and mental health records of long-term care consumers or applicants for long-term care under any of the following conditions:

(a) With consent of the consumer or applicant or his or her legal representative;

(b) Without consent, if the consumer is unable to give consent and there is no legal representative or the state is the individual's representative and the designated agency has received a complaint or has probable cause to believe that abuse or neglect has occurred; or

(c) Without consent, if the consumer is unable to give consent and the legal representative has refused or failed to act on behalf of the individual and the designated agency has received a complaint or has probable cause to believe that abuse or neglect has occurred.

5) Records requested by the designated agency shall be made available for review and copying within three business days or, in the event of death or a request made pursuant to 4(b) or (c), within 24 hours.

6) The designated agency shall maintain an office in each of the service areas of the single points of entry.

7) The designated agency shall coordinate its activities with those of the state long-term care ombudsman and the designated protection and advocacy system.

8) The designated agency shall prepare an annual report and provide information to the public and to policymakers regarding the problems of long-term care consumers.

9) The legislature shall appropriate sufficient funds to enable the designated agency to perform its duties.

SINGLE POINT OF ENTRY
REQUEST FOR PROPOSALS

GRANT ABSTRACTS

Building Options for Cash and Counseling into Michigan's Long-Term Care System

The Michigan Department of Community Health is making application for a grant through the Robert Wood Johnson Foundation's Cash & Counseling Program. The goal of this project is to establish policy direction, practices and technical assistance resources necessary to assure that a "Cash & Counseling" framework is put into place so that consumer-directed and controlled options are readily available to consumers in Michigan's evolving community long-term care system. Developing the framework will require state-level policy development and guidance, and locally developed modeling. A central aspect of this project entails examination of the current MI Choice waiver, to ascertain whether and where changes are needed in order to support Cash & Counseling (C & C) options. This is expected to result in revisions in the MI Choice Waiver in order to assure its compliance with Federal Medicaid requirements for Independence Plus waivers. Grant funding resources will underwrite state- and local-level infrastructure. This infrastructure investment will make it possible for the Department to provide guidance and technical assistance on the C&C methodology to local systems; to identify and include data about C&C experiences in the waiver quality management system; to define and refine best practice methods for supporting implementation in local agencies, specifically the Department's contracted MI Choice Waiver agents.

Michigan has made substantial progress in establishing the components of C&C within its local system of services to persons with mental illness or developmental disabilities, under the rubric of "self-determination". For example, in the Michigan Mental Health system, Person-Centered Planning is a statutory requirement for developing consumer plans of services and many individuals possess plans of services that incorporate an individual budget. As well, the use of financial management services in conjunction with the individual budget provides consumer support as well as agency safeguarding of funds made available for consumer direction. Medicaid managed care waiver arrangements in play in the Michigan Mental Health system assure service options that include a range of flexible alternatives.

However, the statutory basis and administrative operations of public mental health services is separated from planning and delivery from long-term care services. Thus, the values, policies and methodologies of consumer self-determination are not yet part of Michigan's community long-term care services system. Michigan's austere administrative capacity makes the pursuit of Cash & Counseling options in LTC very difficult. Yet consumer advocates and policy leaders expect that consumer-directed and controlled options will be a central aspect of long-term care.

Michigan's purpose in seeking the C&C grant award to develop the capacity to guide and implement changes that will infuse consumer-directed and controlled options into LTC. The primary focus of the grant's activities will be aimed at the MI Choice Waiver, which serves approximately 8,000 individuals with a nursing home level of care. The program will begin with analysis of the waiver, aiming for changes to support the C & C option. Along with this, a State-level coordinator will begin working with three pre-selected pilot MI Choice Waiver agents, each of which is also a Michigan Area Agency on Aging. The focus of these efforts will be on building successful local capacity to promote and support the Cash & Counseling option for MI Choice Waiver consumers. The state-level coordinator will guide and support local pilot site evolution and promote infusion of information and practices to the remaining Mi Choice Waiver sites. The coordinator will be responsible for coordinating the development of needed waiver amendments, including an Independence Plus waiver application. The coordinator will facilitate a State-level project steering committee composed of Mi Choice Waiver agent and provider staff, consumers and consumer representatives. The project steering committee will examine experiences and outcomes, and induce a refined statewide policy direction for Cash & Counseling. It will be the overall goal of the project to assure a comprehensive access to Cash & Counseling options across the Mi Choice Waiver, and to instill as part of Michigan's evolving LTC system coordination activities a strong base for assuring that consumer choice, direction and control is available to those who require LTC services and supports.

Money Follows the Person Initiative

ABSTRACT

The overall goal of the project is to develop and implement the system changes necessary to ensure that *money follows the person*, that an individual's choices drive his/her services and that the aggregate choices of long-term care consumers shape the State's use of resources. This work will be conducted through a partnership between the State agencies and a *LTC Roundtable*, which will include representation by consumers, families, advocates, and nursing facility and community providers. Consumers and families will be supported in their work by a *Community Consortium for Advocacy and Technical Assistance*. This support of and partnership with stakeholders represents a major commitment to inclusive planning for the development of long-term care services.

The project will develop an integrated model for LTC services, including nursing facility services and home and community-based services. This will be done within three local pilot sites. A 1915 (b)(c) waiver will be developed to allow for integrated, capitated pilot sites. The project will also address barriers to *money follows the person* as they exist in state regulations and financing, expecting that some statewide changes will be made concurrent with the development of the pilot sites.

The Community Consortium, administered by the Michigan Disability Rights Coalition, will develop a broad network of informed consumers and families who will provide input to the project's planning and implementation. This will establish a cohesive advocacy voice to guide system changes throughout and beyond the grant. The Consortium will gather data from consumers and families and produce issue papers to inform the system change process.

The LTC Roundtable will be a forum for collaborative problem-solving on critical issues, such as the development of alternatives to traditional nursing home models. A broad spectrum of stakeholders will have a regular forum for working together and working with the State agencies, including the Michigan Department of Community Health and the Office of Services to the Aging.

In developing the pilot sites and integrated models, the project will produce a feasibility plan, an implementation plan and a sustainability plan. The pilot sites will adapt person-centered planning and self-determination methods to LTC services, and have the flexibility to test strategies for improving the direct service workforce, developing housing options, and meeting other challenges to providing effective community-based services. The pilot sites will benefit from technical assistance from the Community Consortium and the Michigan Association of Centers for Independent Living, which will provide nursing home transition services and training to build community support for this key activity. The products from this pilot site activity will include a waiver application, site contracts and policy changes.

This grant application request $746,650 in federal funding for a three-year project. The Michigan Department of Community Health will provide an in-kind match of $37,650.

Independence Plus Initiative

ABSTRACT

This Initiative is focused on accomplishing three goals:

1. Establishing system-wide self-determination options through effective and flexible consumer-controlled services arrangements in the Michigan Mental Health system;

2. Moving the philosophy, information, methods and practices of self-determination and consumer-controlled options to the MI Choice HCBS waiver system, so as to build in similar methodologies to make flexible, consumer-directed options available for beneficiaries who are elderly or disabled;

3. Developing the framework for submitting an Independence Plus waiver arrangement under the authority of Section 1115 of the Social Security Act, thus affording a limited number of beneficiaries from the Mental Health and/or the Long-term care systems with the option of receiving a cash allotment in lieu of formally provided Medicaid support services, which they may self-direct to achieve personally preferred support arrangements in easily accomplished ways.

Michigan has a lengthy history of taking seriously the intent of community care provided in the least restrictive most home-like setting for persons who are elderly, or who require support because of a physical or a mental disability. This grant would expand the implementation of arrangements that support self-determination, using techniques, methods and materials that have been evolving for the past six years of participation in the Robert Wood Johnson Foundation's National Program of Self-Determination for Persons with Developmental Disabilities. In July of this year, the Michigan Department of Community Health issued its final Self-Determination Policy and Practice Guideline, with the expectation that this policy will be fully implemented in the Michigan Mental Health system over the next couple of years. Inculcating change such as this into a large system of local care networks is not a rapid process. In order to achieve this outcome, and to expand these options to other long-term care populations, the Department of Community Health intends to use the resources available through the Independence Plus Initiative to more deeply embed the principles and practices, and expand their application.

The project will be guided by the Department of Community Health in partnership with a Project Work Group composed of consumers and advocates, Department staff, and stakeholders from the Community Mental Health and Long-Term Care services systems.

The grant will provide support for developing a standardized model for individual budget development, accountability, and fiscal intermediary services. The grant will also develop and test models for using independent facilitators and support brokers in person-centered planning. The total budget for the 3-year grant is projected to be$500,000 (plus the 5% recipient contribution).

Real Choice Systems Change 2001

ABSTRACT

The overall goal of this project is to make enduring systems changes within Michigan's community-based services so that individuals receive better care, resulting in greater quality of life. The project has three major components: the Long Term Care Outcomes and Evaluation System Initiative, the Virtual Organization Initiative, and the Consumer Cooperative Initiative. These components are related by the common themes of improved access, consumer control, quality services, quality of life and cost-effectiveness. The benefits of these initiatives will broadly impact individuals of all ages, in each of Michigan's three waivers, and throughout long-term care services.

The LTC Outcomes and Evaluation System Initiative seeks to strengthen our quality assurance and quality improvement system by expanding the roles of consumers and family members in system design, implementation and evaluation; by developing outcomes and quality indicators for the continuum of services from primary/acute care to home and community-based services to nursing facilities; by developing effective methods for assessing consumer satisfaction and quality of life; and by supporting quality improvement initiatives in local agencies.

The Virtual Organization Initiative will develop a model for administering an integrated system of long term care, in which access and service delivery are coordinated across primary/acute care, home and community-based services and nursing facilities. The virtual organization is a business model that (1) allows consumers to use telephone or web technology to identify and arrange services, and communicate needs and satisfaction with services, and (2) allows providers to electronically link into a full service network to better serve customers. It is an opportunity to use the powerful, new e-business technology, combined with assistive technology, to empower consumers and realize greater efficiencies within the system.

The Consumer Co-operative Initiative will develop a model in which consumers and family members will collectively assume responsibility for their outcomes and take control of the resources needed to achieve them. The Co-op will allow members to design and obtain the services they prefer, with more creativity, responsiveness and cost-effectiveness. This model offers an exciting advancement in systems changes in support of consumer-directed services.

This proposal requests funding of $3,478,800 for a 3-year period.

Community-integrated Personal Assistance Services and Supports (C-PASS):

Michigan Quality Community Care Council Overview

Individuals with disabilities, including the elderly, often require assistance and support to carry out the tasks of daily living. For many, the inability to access such assistance places them at risk of deterioration of their health, their safety, and their quality of life. They may then require placement in a residential or institutional setting. With proper assistance, many can remain in their own homes and communities. Michigan's Medicaid-funded Home Help program provides eligible persons with the ability to locate, select, and directly employ a person who will provide the needed home care, while assuring payment to the worker.

A work group of state officials and consumer advocates was established to develop a model for creating a public authority that would function as a co-employer, with consumers, to replace the current independent consumer-employer arrangement. The purpose of the public authority is to provide improved access to qualified direct care workers and to support both consumers and workers in achieving quality outcomes. The Quality Community Care Council (QCCC) was established as a public authority under Public Act 7 of 1967, the Urban Cooperation Act via an Interlocal Agreement between the State and the TriCounty Aging Consortium. A Board of Directors comprised of a majority of consumers and advocacy representatives, appointed by Governor Granholm, governs the QCCC.

Three principles guide the QCCC: a) It is governed primarily by consumers and advocates, b) It ensure the right of the consumer to select, retain, direct, and fire community care workers, and c) It supports workers in order to promote competence, achieve quality consumer outcomes, and improve worker retention through improving job satisfaction.

The major functions of the QCCC include:

- Provide certain employer functions for home care workers and assume the payroll-processing functions and other related employer supports, with consumers as co-employers (with the QCCC) of their home care workers.
- Conduct recruitment and retention programs to expand the pool of direct care workers.
- Establish and maintain a registry of workers to promote access to qualified workers.
- Develop a system that can facilitate the provision of routine, emergency, and respite referrals of qualified workers.
- Address barriers to employment; provide worker information, referral and assistance with access to supports to promote retention and success.

Michigan's Medicaid Infrastructure Grant

Abstract

The overall goal of Michigan's MIG grant is to remove systemic barriers to employment for individuals with disabilities and support the inclusion of individuals in the workforce based upon their personal goals and choices. While Michigan provides many employment services and extensive personal care services, it does not provide personal care services outside of the home. Therefore, Michigan is applying under the conditional level of eligibility. The application is for a two-year period, with a total budget of $1,000,000.

The lack of personal care services outside the home is one of the employment barriers Michigan plans to analyze and impact with the MIG grant. Other barriers include the need for services other than personal care (e.g. transportation, assistive technology) that would support employment for individuals with disabilities; the eligibility constraints of Michigan's Medicaid buy-in program; the impact of other Medicaid policies, such as spend-down; and the need for training professionals (e.g. vocational rehabilitation counselors, community mental health and long term care program case managers, benefits counselors, staff of Centers for Independent Living), employers and consumers about the support options available. The project would analyze these and other barriers as well as successful strategies developed in other states. The project would work with leaders from consumer/advocacy groups, the various state agencies involved in the issues, and employers to design program and policy changes and develop recommendations for the Governor and legislature. In particular, Michigan's Freedom to Work for Individuals with Disabilities Act, implementing Michigan's Medicaid Buy-in plan, requires an evaluation of the impact of this legislation. It is the intent of this proposal to include this evaluation in the project activities.

Michigan's state budget faces severe challenges for the next few years. The Medicaid program is especially problematic, with deficits of $500 million projected for FY 2005. Therefore, any strategies implemented to extend state plan personal care to work settings must be cost-neutral with respect to current expenditures for state plan personal care. Within this condition the state will pursue this extension by analyzing its current experience and options, working in concert with stakeholders to develop and implement strategies that support the opportunity for more Medicaid recipients to work, and develop proposed policy modifications to make personal care available outside the home. Policy and implementation issues will be identified, feasibility studies conducted. Planning will aim for necessary modifications in order to accomplish this goal, during the first year. Implementation of those modifications is intended for the second year.

Michigan will use the grant to analyze its current experience with the Medicaid buy-in, vocational rehabilitation services, its Specialty Mental Health Services waiver, a small state-funded personal care program for employed individuals, and the extensive personal care provided through its Home Help Program. The process of gathering information will also be used to educate informants about their options for employment supports and build support for the employment of individuals with disabilities. This exchange of information should result in a broad understanding of the impact of Medicaid and other policies, and the potential for achieving benefits to individuals, employers and the community in general.

Mental Health Systems Transformation Grant
Project Abstract

The goal of this Mental Health Systems Transformation Grant is to transform Michigan's public mental health system so that recovery is the foundation of the service delivery system. The goal will be accomplished by:

- To facilitate a rapid movement toward a Michigan consensus among consumers, professionals and service system managers about recovery, what it is comprised of, what models and pathways can be delineated and implemented in the Michigan mental health system, to assure that an infrastructure supportive of recovery models is in place as the foundation of services delivery in the public mental health system.
- To assure that leadership within the Michigan Department of Community Health is consumer-centered, sensitive to and informed of consumer experiences, supporting the direction of the Recovery Council and developed products that are truly oriented in partnership with consumer perspectives
- To establish locally-based models of recovery that can serve as learning environments for consumers, families, professionals and service system managers, facilitating local pathways and models that are successfully focused on applying the principles and methods of recovery as the foundation for service delivery.
- Ensure that application of principles of recovery as the basis for service delivery is expanded across the public mental health system through continuous learning and expanded partnerships between consumers, service managers and professionals.

Michigan has a strong history of promoting and supporting consumer choice and control in the delivery of mental health services and supports. Our evolution is directly a result of the partnerships we have with consumers and families. We have open forums, public comment, and consumer and family representation on workgroups in developing practice guidelines, technical advisories and other communications to the field. In providing services and supports to persons with serious mental illness we have person-centered planning in our Mental Health Code and a Self-Determination Policy and Practice Guideline that will be effective October 1, 2004. These innovations have moved professionals and systems into a service delivery model of consumer choice and control, however we have had pockets of success without significant systems change. Michigan lacks a foundation in recovery. Recovery education, training and support are necessary to continue our evolution in supporting positive practices that are evidenced based. The Mental Health: Systems Transformation grant would provide the needed change to support the person-centered planning process and the pathway to developing self-determined arrangements for persons with mental illness. This project is directed and lead by a Recovery Council with membership including over fifty percent primary consumers. A fulltime primary consumer will assist in providing the technical assistance needed to support consumers and other stakeholders in the state. Outcomes derived from the grant will have long-term benefits resulting in sustainable products and partnerships. Outcomes will minimally include a Council of experts, recovery brochure and handbook, website with links to national resources, Recovery Centers of Excellence, a Policy and Practice Guideline on Recovery, speakers bureau, contract requirements, and developing the infrastructure to support recovery-oriented evidenced-based mental health services.

Aged and Disabled Resource Center Grant

Executive Summary

The Michigan Office of Long Term Care Supports and Services, in partnership with the state unit on aging and the single state Medicaid agency, proposes to create a network of aging and disability resource centers (ADRC). This will be accomplished through the realignment and enhancement of existing infrastructure. Executive Order 2005-14 issued by Governor Jennifer M. Granholm on June 9, 2005 authorizes and funds the establishment of three pioneer single point of entry (SPE) sites in FY 2006, one located in an urban area and at least one in a rural area. Funding provided through this grant will be used to develop the organizational and operational templates that will guide development of these first three sites and the eventual realignment in the remainder of the state. In year 3 of the grant, effort will be placed on a comprehensive evaluation of pioneer site performance and developing an action plan to achieve statewide expansion.

The ADRC will serve as a comprehensive resource on long term care and provide information and assistance in accessing services, planning for long term care financing and delivery, benefits outreach and proactive choice counseling for the general population. ADRCs will serve as the single point of entry (SPE) for elderly and physically disabled adults to Michigan's Medicaid-funded long term care system. In this capacity, the ADRC will conduct medical and facilitate financial eligibility determination for Medicaid-funded supports and services provided in nursing facilities and the MI Choice waiver. Use of the ADRC/SPE will be mandatory for individuals seeking access to Medicaid-funded nursing facility level of care programs. For this population, ADRC/SPEs will perform the key functions of assessment, supports coordination and service authorization.

Financial assistance provided through this grant will be used to support local planning initiatives, establish a single, toll-free, geo-routed telephone number (1-866-MICH-LTC), develop and provide training and enhancement of information technology to support ADRC activities.

Grant activities will be coordinated from the Department of Community Health Office of Long Term Supports and Services in coordination with the Office of Services to the Aging, the Medical Services Administration, and the Department of Human Services.

STATE LTC RESOURCES

MICHIGAN
LONG-TERM CARE
STATE GOVERNMENT RESOURCES
2-28-06

OFFICE	RESPONSIBILITY
Department of Human Services (DHS)	
Adult Protective Services	Investigate allegations of abuse, neglect or exploitation and provide protection to vulnerable adults. http://www.michigan.gov/dhs/0,1607,%207-124-5452_7119-15663--,00.html
Adult and Family Services (Home Help)	Range of Medicaid and nonMedicaid services to individuals of any age who require consultation or assistance to maintain and maximize functional capacity within their own homes or other independent living arrangements. This is also called "Home Help" for Medicaid consumers. Services include: • Information and referral • Protection (guardian/conservator) • Counseling • Education • Employment and training • Health related • Money management http://www.michigan.gov/dhs/0,1607,7-124-5452_7122-15667--,00.html
Adult Community Placement	Assistance to individuals and families in locating and selecting licensed community care facilities for people who can no longer live independently. Licensed care settings include adult foster care (AFC) facilities, Homes for the Aged (HA), and nursing care facilities. Program staff is also responsible for assuring that a monthly personal care/supplemental payment is made to the facilities. http://www.michigan.gov/dhs/0,1607,%207-124-5452_7122-15670--,00.html
Legal Affairs and Financial Integrity	Licensing and regulation of family, small, large, and congregate adult foster care homes, homes for the aged, and specialized programs for developmentally disabled and/or mentally ill individuals who reside in adult foster care homes. http://www.michigan.gov/dhs/0,1607,7-124-5455_27716_27717---,00.html
Department of Labor and Economic Growth (DLEG)	
Division on Deaf and Hard of Hearing	• Technical support • Information and Referral Services • Accommodations • Interpreter Information and Services • Research and Statistics

	http://www.michigan.gov/cis/0,1607,7-154-28077-23760--,00.html
Michigan Commission for the Blind	• Vocational Rehabilitation Services • DeafBlind Services • Youth Services • Business Enterprise Program • MCB Training Center http://www.michigan.gov/cis/0,1607,7-154-28077_28313---,00.html
Senior Blind Program	Independent Living (IL) Services is a federal-state partnership providing services to older blind individuals so they can be as independent in their daily lives as possible. Services include information and referral, rehabilitation teaching services, orientation and mobility, low-vision services, adapted aids and appliances, daily living skills, leisure activities, counseling, Braille and other communication methods, and peer support groups. http://www.michigan.gov/cis/0,1607,7-154-28077_28313_33133---,00.html
Michigan Commission on Disability Concerns	Information and referral assistance, disability rights training, working with the Michigan Business Leaders Network on employment for people with disabilities, coordinating the Michigan Youth Leadership Forum and conducting disability awareness and sensitivity training. http://www.michigan.gov/cis/0,1607,7-154-28077_28545---,00.html
Michigan Disability Resource Directory	This directory is to help individuals and families locate disability services in an easy-to-use resource directory. www.http://www.michigan.gov/cis/0,1607,7-154-28077-22397--,00.html
Michigan State Housing Development Authority (MSHDA)	
	Provides financial and technical assistance through public and private partnerships to create and preserve decent, affordable housing for low- and moderate-income Michigan residents. Proceeds of the bonds and notes are loaned at below-market interest rates to developers of rental housing, and also fund home mortgages and home improvement loans. http://www.michigan.gov/mshda
Michigan Rehabilitation Services (MRS)	
	MRS will work with the customer to decide on an employment goal, develop a plan, follow the plan, and reach the goal. The following services may be provided and are free of charge: Disability assessments, vocational evaluations, counseling, job placement services and job follow-up services. http://www.michigan.gov/mdcd/0,1607,7-122-1681_2818---,00.html
Michigan Department of Community Health (DCH)	
Office of Long-Term	Administer activities to implement the recommendations of the Long-

Care Supports and Services	Term Care Task Force; coordinate state planning for long-term care supports and services; conduct efficiency, effectiveness, and quality assurance reviews of publicly-funded long-term care programs; identify and make recommendations regarding opportunities to increase consumer supports and services, organizational efficiency, and cost effectiveness within Michigan's long-term care system; oversee the implementation of the single point of entry demonstration programs.
Michigan Developmental Disabilities Council	Planning and public information; monitoring; planning, advocacy and resource development http://www.michigan.gov/mdch/0,1607,7-132-2941_4868_4897---,00.html
Medical Services Administration	Medicaid policy, eligibility, and actuarial services; revenue and reimbursement (court-originated liability, state facility and CMHSP reimbursement, third-party liability and cost avoidance); MIChoice waiver; LTC operations support; program investigation; Medicaid payments, including institutional reimbursement; program review and investigation (prior authorization); cost data reporting and reimbursement; customer services (MA hotline), and data management; intertribal liaison; provider enrollment; Medicare Buy-In. http://www.michigan.gov/mdch/0,1607,7-132-2943_4860---,00.html
Health Policy, Regulation, and Professions Administration	Health systems (nursing home monitoring, licensing and certification for hospitals, operations, and health facilities evaluation) access to care; Certificate of Need; health care workforce issues; health professions (investigation, complaint and allegation, licensing); http://www.michigan.gov/mdch/0,1607,7-132-27417---,00.html
Mental Health and Substance Abuse Services	Hospital, center, and forensic mental health services; community mental health services (program development, consultation, and contracts); quality management and planning (performance measurement and evaluation; quality assurance); consumer relations; specialty managed care; community living and long-term care planning (housing; OBRA/PASARR); consumer-directed home and community-based services (federal grants); mental health services to children and families (programs for children with serious emotional disturbance, child federal block grants, children's waiver, family subsidy) http://www.michigan.gov/mdch/0,1607,7-132-2941_4868---,00.html
Office of Services to the Aging (OSA)	
	Provides standards, information, education and assistance to seniors, caregivers and families, job seekers, professionals, advocates, and researchers. http://www.miseniors.net/MiSeniors+Home/

SUMMARIES LTC ACTIVITIES

Long Term Care Work Groups
As of March 2006

AARP Michigan LTC reform Coordinated Campaign Council – This group is comprised of provider and consumer organizations focusing on maintaining transparency of efforts among the member organization and networks to foster full, long-range implementation of the Governor's Medicaid Task Force Recommendations, particularly via specific state legislation. The State AARP Director, Steve Gools, is the chair of this group.

Disability Caucus - This group of legislators is working to investigate and promote issues important to people with disabilities in Michigan, including long-term care issues.

Governor's Task Force on Long Term Care - Chaired by RoAnne Chaney of Michigan Disability Rights Coalition, this group met for several months to review existing reports of efficiency and effectiveness of the current long-term care system, examine the quality of Michigan's long-term care services, report on the existing federal and state funding mechanisms for long-term care and its sustainability, identify and recommend benchmarks for measuring successes in the provision of long-term care services, and identify and make recommendations to reduce barriers to the long-term care system. This task force published its' recommendations in May of 2005. This report may be reviewed via internet at: http://www.ihcs.msu.edu/LTC/default.htm

Health Issues Work Group - The Michigan Developmental Disabilities Council established a Health Issues Work Group, chaired by Yvonne Fleener, with the mission to increase the quality, availability and range of health care supports and services statewide. The workgroup has proposed, and the council has preliminarily concurred, to fund a three-year care coordination project in four diverse sites across the state. The project purpose is to implement care coordination models that reflect: person-centered planning/consumer choice; the broad concept of team development and monitoring of an individual plan; the inclusion of "non-covered" services in the development and monitoring of a plan; and continuity of care across the life span. The target population includes persons with developmental disabilities within and outside the CMH system and others with disabilities with multiple chronic conditions/complex health care needs.

MACIL-LTC - This group, chaired by RoAnne Chaney, MDRC, is focused on nursing facility transitions and collaborating within the disability and aging communities by bringing all interested CILs together with allies to plan for local efforts and involvement in statewide long-term care reform initiatives.

MDCH Consumer Task Force - Facilitated by Mike Head, MDCH, this group oversees and provides input on federally-funded long term care grants.

MI Choice Person Focused Quality Management - This group, chaired by RoAnne Chaney of MDRC, and Pam McNab of MDCH, developed a quality measures plan for the MIChoice waiver program and continues to meet quarterly.

MI Choice Coalition - This statewide group of agencies, organizations and individuals, affiliated with AAAs is advocating for restoration and expansion of the waiver and community-based options.

Michigan Campaign for Quality Care - A grassroots consumer group seeking better care, better quality of life and better choices for Michigan's long-term care consumers. This group is chaired by Nadene Mitcham and coordinated by Alison Hirschel of Michigan Poverty Law Program.

Michigan Quality Community Care Council - This agency, established via a public authority, co-employs home help workers across the state, giving them the opportunity to participate in learning opportunities, mentorship experiences, health insurance, and be listed on a registry for consumer use.

Olmstead Coalition – Co-Chaired by Mary Ablan of the Michigan Association of Agencies on Aging and Carolyn Lejuste of MDRC, this group is a non-partisan, non-profit coalition dedicated to making community-based long-term care available to all who need it.

> **Policy Subcommittee**—This group meets on an ad hoc basis around specific policy issues is a part of the Olmstead Coalition and has been very active in advocating for the Home and Community-Based Services.

Long-Term Care Commission – Created by Executive Order 2005-14 and appointed by the Governor, chaired by Marsha Moers. This commission is composed of 17 members representing providers, consumers, and advocates to act in an advisory capacity to:

1. Review and monitor the implementation of the recommendations of the Task Force
2. Review and comment upon quality assurance reviews of Michigan's long-term care system
3. Serve in an effective and visible consumer advocacy role for improving the quality of, and access to, LTC supports/services.
4. Participate in the preparation and review of an on-going, comprehensive statewide plan and resources plan for long-term care supports and services to address and meet identified consumer preferences and needs.
5. Ensure the broadest possible on-going public participation in statewide planning.

6. Promote broad, culturally competent, and effective public education initiatives about long-term care issues and choices and provide opportunities for direct involvement by the public.
7. Recommend a performance evaluation in the single point of entry demonstration programs required by the Order and make recommendations for the improvement of the single point of entry system in this state.
8. Discuss potential changes in policy that would encourage more effective provision of long-term care supports and services.

LTC FUNDING

FLOW CHARTS

PENDING LEGISLATION

Legislative Analysis

Mitchell Bean, Director
Phone: (517) 373-8080
http://www.house.mi.gov/hfa

INCOME TAX EXEMPTION: CARING FOR PARENT

House Bill 4337
Sponsor: Rep. Rick Shaffer
1st Committee: Tax Policy
2nd Committee: Senior Health, Security, and Retirement

Complete to 1-3-06

A SUMMARY OF HOUSE BILL 4337 AS INTRODUCED 2-17-05

The bill would amend the Income Tax Act to allow a taxpayer to claim an additional exemption of $1,800 if the taxpayer provides primary care for a parent who is a "senior citizen" and if the Department of Human Services determines that such care prevents institutionalization of that parent. The bill would apply to tax years beginning after December 31, 2004. [An exemption reduces the amount of income subject to tax.]

The bill defines "primary care" to mean acts that meet the physical or mental requirements of a family member who cannot meet those requirements without assistance or supervision, including acts relating to health, safety, nutrition, hygiene, homemaking, or other activities of daily living.

The act currently defines "senior citizen" to mean an individual who is 65 years of age or older or the unremarried surviving spouse of an individual who was 65 years of age or older at the time of death.

MCL 206.30

FISCAL IMPACT:

The bill would reduce income tax revenue by a small, indeterminate amount. The resulting reduction would likely be less than $1.5 million.

Legislative Analyst: Mark Wolf
Fiscal Analyst: Jim Stansell

Legislative Analysis

Mitchell Bean, Director
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http://www.house.mi.gov/hfa

INCOME TAX DEDUCTION FOR LONG TERM CARE INSURANCE

House Bill 4021
Sponsor: Rep. Roger Kahn
Committee: Tax Policy

Complete to 2-8-05

A SUMMARY OF HOUSE BILL 4021 AS INTRODUCED 1-27-05

The bill would amend the Income Tax Act to allow taxpayers to deduct from taxable income the premiums paid in the tax year to obtain long-term care benefits from an insurance policy. The deduction would apply for tax years beginning after December 31, 2005, and would apply to the extent the premiums had not already been deducted in determining adjusted gross income.

MCL 206.30

FISCAL IMPACT:

The bill would reduce income tax revenue by an estimated $21 million in tax year 2006. About 77 percent of this reduction would affect the General Fund and 23 percent would affect the School Aid Fund. To the extent tax benefits are taken through refunds, the impact on the General Fund would be greater and the impact on the School Aid Fund less.

Legislative Analyst: Mark Wolf
Fiscal Analyst: Rebecca Ross

Legislative Analysis

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http://www.house.mi.gov/hfa

LONG-TERM CARE INSURANCE REGULATION

House Bill 5349 (Substitute H-2)
Sponsor: Rep. Paula K. Zelenko

House Bill 5348 as introduced
Sponsor: Rep. Kevin Green
Committee: Senior Health, Security, and Retirement

First Analysis (2-15-06)

BRIEF SUMMARY: House Bill 5349 would amend Chapter 39 of the Insurance Code, which deals with long-term care insurance, to make a number of amendments that incorporate features of a model act developed by the National Association of Insurance Commissioners. The amendments would add consumer protections, including requiring policies to contain nonforfeiture benefits and contingent benefits to prevent the loss of coverage when policy premiums increase; revise rate-making regulations; and address agent training requirements. House Bill 5348 would bring long-term care coverage provided by Blue Cross Blue Shield of Michigan under the code (and repeal long-term care provisions in the act governing BCMSM), and would specifically include assisted living facilities as a setting where services covered by long-term care insurance could be provided.

FISCAL IMPACT: There would be no significant fiscal impact on the State of Michigan and its local units of government.

THE APPARENT PROBLEM:

Insurance policies that cover long-term care are a relatively new insurance product, little more than two decades old. Michigan first passed laws directly addressing such policies in 1989. To quote from a guide to long-term care insurance produced by the National Association of Insurance Commissioners (NAIC):

Someone with a long physical illness, a disability, or a cognitive impairment (such as Alzheimer's Disease) often needs long-term care. Many different services help people with chronic conditions overcome limitations that keep them from being independent. Long-term care is different from traditional medical care. Long-term care helps one live as he or she lives now; it may not help to improve or correct medical problems. Long-term care services may include help with activities of daily living, home health care, respite care, adult day care, care in a nursing home, and care in an assisted living facility. Long-term care may also include care management services, which will evaluate [a person's] needs and coordinate and monitor the delivery of long-term care services.

Michigan's law governing long-term care insurance policies has not seen substantial amendments in many years. Insurance regulators note that the NAIC adopted new model

legislation on the topic in 2000, but Michigan has yet to adopt that model. Legislation has been introduced that would incorporate provisions regard rate-setting and consumer protections from the 2000 model into Michigan's Insurance Code.

THE CONTENT OF THE BILL:

House Bill 5349 would amend Chapter 39 of the Insurance Code, which deals with long-term care insurance. The following is a general description of key provisions.

** A long term care policy or certificate could not be issued until the insurance company had received from the applicant either (1) a written **designation of at least one other person** who is to receive **notice of lapse or termination** of the policy or certificate for nonpayment of premium; or (2) a written waiver dated and signed by the applicant for the policy electing not to designate such a person. (This would not apply when payment was made through a payroll or pension deduction plan.)

** An individual long-term care policy or certificate **could not lapse or be terminated** for nonpayment of premium unless the insurance company gave **at least 30 days' written notice** to the insured and any designee. A policy would have to provide for **reinstatement of coverage** if the company was provided proof that the policyholder was cognitively impaired or had a loss of functional capacity before the grace period expired. The reinstatement option would be available if requested within five months after termination.

** Long-term care insurers would have to offer applicants the option of purchasing a policy that includes a **nonforfeiture benefit**. The offer would have to be in writing and could be in the form of a rider attached to the policy. If the customer declined the offer, the company would have to provide instead a **contingent benefit upon lapse** available for a specified period of time after a substantial increase in premium rates. The commissioner of the Office of Financial and Insurance Services (OFIS) would have to promulgate rules specifying the type of nonforfeiture benefits to be offered, the standards for such benefits, and the rules regarding contingent benefit upon lapse.

** Generally speaking, a **nonforfeiture benefit** refers to a provision in an insurance policy that grants benefits when a policy lapses so that the equity in the policy to that point is not forfeited. Under the bill, the nonforfeiture benefit would be a shortened benefit period providing paid-up long-term care insurance after the lapse of the policy. The bill describes how the standard nonforfeiture credit is to be calculated. Nonforfeiture benefits could be used for all care and services qualifying for benefits under the terms of the policy, up to the limits specified in the policy. A policy or certificate offered with nonforfeiture benefits would have to contain coverage elements, eligibility, benefit triggers, and benefit length that were the same as coverage issued without nonforfeiture benefits.

** For qualified long-term care insurance contracts that are **level premium contracts**, a company would have to offer **nonforfeiture benefits** that (1) are properly captioned; (2)

provide a benefit available in the event of a default in premium payments, with the amount of the benefit permitted to be modified to reflect changes in rates for premium-paying contracts; and (3) provides at least reduced paid-up insurance; extended term insurance; a shortened benefit period; or similar commissioner-approved options.

[An insurance company marketing long-term care insurance could not use the term "**level premium**" or the term "noncancelable" unless the company did not have a right to change the premium for the product being marketed.]

** The **contingent benefit upon lapse** would be triggered every time an insurance company increased the premium rates to a level that resulted in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial premium, based on the insurer's issue age, and the policy lapses within 120 days of the due date of the premium being increased. The bill contains a chart providing the triggers. On or before the date of a substantial premium increase, the insurance company would have to offer to reduce policy benefits so that premium payments are not increased; offer to convert the policy to a paid-up status with a shortened benefit period; and notify the policyholder or certificateholder that a default or lapse during the 120-day period would be considered an election of the offer to convert to paid-up status.

** A long-term care policy would have to allow a policyholder **to reduce coverage and lower the premium** in at least the following ways: by reducing the lifetime maximum benefit; by reducing the nursing facility per diem and reducing the home- and community-based service benefits of a home care-only policy and of a comprehensive policy; or by converting a comprehensive policy to a nursing facility-only policy or a home care-only policy, if the company issues those policies in the state. The customer would choose one of those options. A company could provide additional options.

** Every insurer or other entity marketing long-term care insurance would have to develop and use **suitability standards** to determine whether the purchase or replacement of long-term care insurance was appropriate for the needs of the applicant; train its agents in the use of the standards and require them to use them; and maintain a copy of the suitability standards and make them available to the OFIS commissioner upon request.

** An insurer would have to **provide applicants with information about rates**, including a statement that the policy may be subject to future rate increases; an explanation of customer options in the event of a rate increase; historical information about premium rate increases over the past ten years; as well as information about current rate schedules. A company would have to provide notice of an upcoming premium rate schedule increase at least 45 days prior to the increase.

** An insurer would also have to provide to an applicant 61 years of age or older, or who is disabled, a **current brochure from the state's Medicare/Medicaid Assistance Program** containing information on the availability of free and independent insurance purchasing and public benefits counseling. The company could, in the alternative,

provide the web address where the brochure could be obtained and the telephone number of the agency that could provide the brochure.

** At least 30 days prior to making a long-term care policy available for sale, an insurer would be required to provide **rate information** of the kind listed above **to the commissioner of the Office of Financial and Insurance Services**, along with **an actuarial certification**. The actuarial certification would have to consist at minimum of: a statement that the initial premium rate schedule was sufficient to cover anticipated costs under moderately adverse experience and was reasonably expected to be sustainable over the life of the policy without future premium increases; a statement that the policy design and coverage had been reviewed and taken into consideration; a statement that the underwriting and claims adjudication processes had been reviewed and taken into consideration; a complete description of the basis for contract reserves; and a statement that the premium rate schedule is not less than the schedule for existing similar policies available from the company (except for reasonably differences, which would have to be explained).

** If the commissioner determined that the actual experience following a rate increase did not adequately match the projected experience and that current projections under moderately adverse conditions demonstrated that incurred claims would not exceed the proportions of premiums predicted, **the commissioner could require the insurer to implement rate adjustments or other measures** to reduce the difference between projected and actual experience.

** An insurance company would have to provide **notice of a pending premium rate schedule increase**, including an "exceptional increase," to the commissioner at least 30 days prior to the notice to policyholders. The notice would have to include: certification by a qualified actuary that if the increase was implemented and the underlying assumptions realized that no further rate increases would be anticipated; an actuarial memorandum justifying the rate schedule change request; a statement that renewal premium rate schedules were not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification was provided to the commissioner; and sufficient information for review and approval of the rate schedule increase by the commissioner.

** The term **"exceptional increase"** would refer to premium rate increases justified due changes in laws or regulations applicable to long-term care insurance or due to increased and unexpected utilization that affected the majority of insurers marketing similar products. Exceptional increases in rates would have to provide that 70 percent of the present value of projected additional premiums be returned to policyholders in benefits.

** In certain cases, when evaluating a proposed rate increase that was not the first increase for the policy in question, the OFIS commissioner could determine that a **rate spiral** existed. This determination would be based on a review of the lapse rates of policies that had been subject to a previous rate increase. Where "significant adverse lapsation" had occurred, the commissioner could determine that a rate spiral existed.

** Following determination that a rate spiral existed, the commissioner could require the company to offer, without underwriting, to all in force insureds subject to the rate increase, the **option to replace existing coverage** with one or more reasonably comparable products being offered by the insurer or its affiliates. An offer would be subject to the commissioner's approval, have to be based on actuarially sound principles (using attained age), and provide that maximum benefits under any new policy accepted by an insured would be reduced by comparable benefits already paid under the existing policy.

** If the commissioner determined that an insurer had exhibited **a persistent practice of filing inadequate initial premium rates**, the commissioner could prohibit the company from filing and marketing comparable coverage for up to five years or from offering all similar coverages and limiting marketing of new applications to products subject to recent premium rate schedule increases.

** For **each implemented rate increase**, the insurance company would have to file **updated projections annually for the next three years for review and approval by the commissioner**, and would have to include a comparison of actual results to projected values. The commissioner could extend the period to greater than three years if actual results were not consistent with projected values from prior projections. The projection would have to be provided to the group policyholder in lieu of filing with the commissioner when a policy insured 250 or more persons and the group was an employer or labor organization group with 5,000 or more eligible employees of a single employer or the group policyholder paid a material portion (at least 20 percent) of the total premium for the group. If any premium rate was greater than 200 percent of the comparable rate in the initial schedule, lifetime projections would have to be filed for review and approval by the commissioner every five years. (As before, the projections would be provided to the large group policyholder in lieu of filing with the commissioner.)

** Each producer (agent) authorized to solicit individual consumers for the sale of long-term care insurance would have to complete eight hours of **training in long-term care** topics during the 24-month period prior to first soliciting individual consumers, (which would be part of, not in addition to, current training requirements). This training would also count toward continuing education required for the first license renewal period after the initial training. In each subsequent renewal period, the need for and amount of additional training in long-term care, as part of mandatory continuing education, would be determined by the producer. (The training requirements are in Chapter 12, which is the chapter that deals with agents, solicitors, adjustors, and counselors

** The **required training** would have to consist of topics related to long-term care insurance and services, including state regulations and requirements; available services and providers; changes or improvements in services or providers; alternatives to the purchase of long-term care insurance; differences in eligibility for benefits and tax treatment between policies intended to federally qualified and those not intended to be

federally qualified; the effect of inflation on eroding the value of benefits and the importance of inflation protection; and consumer suitability standards and guidelines.

** The bill would specify that if the National Association of Insurance Commissioners (NAIC) adopts **a model law, regulation, or guideline that is inconsistent** with Chapter 39, OFIS would have to report in writing to the standing committees of the House of Representatives and Senate on insurance issues within 90 days of its adoption. The report would have to cover the substance of the model law, regulation, or guideline; how it differs from state law; and what changes were needed to state law as a result.

With some exceptions, the provisions in House Bill 5349 would apply to policies and certificates issued on or after January 1, 2007. Generally speaking, the bill does not affect life insurance policies that provide long-term care through accelerated benefits.

House Bill 5348 would amend the Insurance Code to bring long-term care coverage provided by Blue Cross Blue Shield of Michigan under the code. It would repeal the sections dealing with long-term care coverage in the act that governs BCBSM, the Nonprofit Health Care Corporation Reform Act. (BCBSM can only provide this coverage through a subsidiary that is not tax exempt.) House Bill 5348 also would include assisted living facilities as a setting where services covered by long-term care insurance could be provided.

BACKGROUND INFORMATION:

A useful *Shopper's Guide to Long-Term Care Insurance*, provided by the National Association of Insurance Commissioners is available at the following website.
http://www.michigan.gov/documents/cis_ofis_ltcshop_23739_7.pdf

ARGUMENTS:

For:

House Bill 5349 would update Michigan's law regulating the sale of long-term care insurance, for the most part by adopting provisions found in the model legislation approved in 2000 by the National Association of Insurance Commissioners (NAIC). The bill contains some significant consumer protections. For example, the bill would require insurance companies to allow a customer to designate another person as an additional person to receive notices if a policy was about to lapse due to nonpayment. This could prevent cases where a policyholder falls ill or is otherwise unable to respond to his or her mail, misses premium payments, and then loses coverage as a result.

The "nonforfeiture" benefit and "contingent benefits upon lapse" provisions are also important protections. These provisions would mean that a person faced with losing all coverage because they cannot afford to continue paying policy premiums (particularly when premiums rise substantially) would instead be able to continue to receive coverage, albeit at lower levels. This could lead to a paid-up policy with a shortened benefit period.

The bill also offers policyholders faced with rising premiums the option of keeping premiums the same and reducing coverage, using several options.

The bill would require companies to develop suitability standards that would be used to determine if the purchase or replacement of a long-term care policy made sense for a customer; the company would be required to train its agents in the use of such standards. This should help consumers make better decisions about a complicated product. Customers would also be provided with access to a brochure from the state's Medicare/Medicaid Assistance Program containing information on the availability of free and independent insurance purchasing and public benefits counseling.

Customers would have to be provided, under the bill, with information about premium rate schedules, the likelihood of rate increases, and the options available to the customer in the event of a rate increase. The bill also requires some additional training for producers (agents) in the intricacies of long-term care insurance and long-term care services.

Response:

Representatives of life insurance companies, which generally support the proposed legislation, would prefer that the adoption of a provision addressing how a policyholder could reduce coverage and lower the cost of a policy be delayed until discussions underway at the national level are complete. This topic is currently under discussion in the ongoing revision of the model act by the National Association of Insurance Commissioners. It would make sense to wait until those discussions are complete so that companies would not face a Michigan law that is different from regulations elsewhere.

For:

House Bill 5349 contains a number of additional provisions regarding rate regulation by state regulators. An analysis from OFIS says the rate provisions will bring rate stability to the long-term care insurance market. The analysis also says the following about these provisions:

These sections produce standards that give specifics about how policies must be rated when initially marketed and in later years. This language puts all insurance companies on the same footing when they make their initial rating schedules. In the past some insurers would bring a new product into the market with a low price hoping to capture large market share only to find as the policies matured that their products were underpriced and large rate increases were needed to pay benefits. At this older age, policyholders cannot buy a new policy with another company without paying a much higher premium than they would have paid had they initially purchased that company's policy, instead of purchasing the lower [priced] policy.

For:

House Bill 5348 would bring long-term care coverage provided by Blue Cross Blue Shield of Michigan under the code, and would repeal the sections dealing with long-term care coverage in the act that governs BCBSM, the Nonprofit Health Care Corporation Reform Act. This would mean that when amendments were needed to address long-term

care insurance law, only one statute would need amending rather than two. (BCBSM can only provide this coverage through a subsidiary that is not tax exempt.)

The bill also would include assisted living facilities as a setting where services covered by long-term care insurance could be provided. OFIS says that adding this language will help resolve the problem caused when a long-term care policy requires services be provided in a licensed facility. Michigan inspects but does not license assisted living facilities; this language is aimed at allowing policyholder to collect long-term care benefits when in the assisted living setting.

POSITIONS:

The Office of Financial and Insurance Services (OFIS) supports the bills. (2-13-06)

AARP Michigan supports the bill. (2-13-06)

The Life Insurance Association of Michigan and The American Council of Life Insurers both support the bill with amendments to remove Section 3910b, dealing with ways to reduce coverage and lower premiums, until the latest NAIC model language is finalized. (2-13-06)

The Michigan Association of Insurance and Financial Advisors is neutral on the bill but indicated it would support the bill if it required producers to receive education about long-term care as part of their initial training but not as a continuing education requirement. (2-13-06)

Legislative Analyst: Chris Couch
Fiscal Analyst: Richard Child

Senate Fiscal Agency
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BILL ANALYSIS

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Senate Bill 880 (Substitute S-2 as reported by the Committee of the Whole)
Sponsor: Senator Gerald Van Woerkom
Committee: Banking and Financial Institutions

CONTENT

The bill would create Chapter 41a ("Annuity Recommendation to Senior Consumer") of the Insurance Code to require an insurance producer or insurer to have reasonable grounds to believe that a recommendation to a senior consumer to purchase or exchange an annuity was suitable to the consumer based on his or her financial situation. Before executing a purchase or exchange, an insurance producer or insurer would have to make reasonable efforts to obtain the senior consumer's financial status, tax status, and investment objectives.

The bill also would require an insurer to establish and maintain a system to supervise recommendations, designed to achieve compliance with the bill, or assure that such a system was established and maintained. An insurer could contract with a third party, including an insurance producer, to meet this requirement. An insurer that complied with National Association of Securities Dealers rules pertaining to suitability, or rules at least as stringent as those rules, would satisfy the requirements of Chapter 41a for the recommendation of variable annuities.

In addition to penalties provided for under the Code, the bill would allow the Commissioner of the Office of Financial and Insurance Services to order an insurer or insurance producer to take corrective action for a senior consumer harmed by a violation of Chapter 41a. If corrective action were taken promptly after a violation was discovered, the Commissioner could reduce a penalty for a violation of the requirements to assure, adopt, or establish a system to supervise recommendations.

The bill would not apply to any recommendation to purchase or exchange an annuity involving direct response solicitations, where there was no recommendation based on information collected from the senior consumer. The bill also would not apply to a recommendation involving contracts used to fund: an employee pension or welfare benefit plan covered by the Federal Employee Retirement and Income Security Act; certain employer-established or –maintained pension, profit-sharing, deferred compensation, or stock bonus plans, including 401(k) plans; certain government or church pension or deferred compensation plans, or deferred compensation plans of a State or local government or tax-exempt organization; a nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor; settlements of, or assumptions of liabilities associated with, personal injury litigation or any dispute or claim resolution process; or formal prepaid funeral contracts.

MCL 500.4151-500.4165 Legislative Analyst: Patrick Affholter

FISCAL IMPACT

The bill would have no fiscal impact on State or local government.

Date Completed: 2-8-06 Fiscal Analyst: Elizabeth Pratt, Maria Tyszkiewicz

floor\sb880 Analysis available @ http://www.michiganlegislature.org

SENATE BILL No. 820

October 19, 2005, Introduced by Senator SWITALSKI and referred to the Committee on Appropriations.

A bill to amend 1939 PA 280, entitled

"The social welfare act,"

(MCL 400.1 to 400.119b) by adding sections 112g, 112h, 112i, and 112j.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

SEC. 112G. (1) SUBJECT TO SECTION 112C(4) AND EXCEPT AS PROVIDED IN SECTION 112C(5)(B), THE DEPARTMENT SHALL ESTABLISH AND OPERATE THE MICHIGAN ESTATE RECOVERY PROGRAM TO COMPLY WITH REQUIREMENTS CONTAINED IN SECTION 1917 OF TITLE XIX.

(2) THE DEPARTMENT SHALL ESTABLISH AN ESTATE RECOVERY PROGRAM OR CONTRACT VARIOUS ESTATE RECOVERY PROGRAM ACTIVITIES. THESE ACTIVITIES SHALL INCLUDE, AT A MINIMUM, ALL OF THE FOLLOWING:

(A) PLACING AND RECORDING LIENS ON MEDICAL ASSISTANCE

SENATE BILL No. 820

RECIPIENT PROPERTY TO THE EXTENT PERMITTED BY SECTION 1917(A) OF TITLE XIX.

(B) TRACKING ASSETS AND SERVICES OF RECIPIENTS OF MEDICAL ASSISTANCE THAT ARE SUBJECT TO ESTATE RECOVERY.

(C) ACTIONS NECESSARY TO COLLECT AMOUNTS SUBJECT TO ESTATE RECOVERY FOR MEDICAL SERVICES AS DETERMINED ACCORDING TO SUBSECTION (3)(A) PROVIDED TO RECIPIENTS IDENTIFIED IN SUBSECTION (3)(B). AMOUNTS SUBJECT TO RECOVERY SHALL BE EQUAL TO THE COST OF PROVIDING THE MEDICAL SERVICES. THE MEDICAID ESTATE RECOVERY PROGRAM MAY NEGOTIATE ACCELERATED SETTLEMENTS OF ESTATE RECOVERY CLAIMS WITH THE SPOUSES AND HEIRS OF RECIPIENTS SUBJECT TO ESTATE RECOVERY IF THE RECIPIENT IS UNLIKELY TO RETURN TO HIS OR HER HOME. THE SETTLEMENTS SHALL TAKE INTO ACCOUNT THE BEST INTERESTS OF THE STATE AND THE SPOUSE AND HEIRS.

(D) PERFORM OTHER ACTIVITIES NECESSARY TO EFFICIENTLY AND EFFECTIVELY ADMINISTER THE PROGRAM, INCLUDING RECEIVING INFORMATION AND NOTICES RECEIVED UNDER SECTION 2843 OF THE PUBLIC HEALTH CODE, 1978 PA 368, MCL 333.2843.

(3) THE DEPARTMENT SHALL SEEK APPROPRIATE CHANGES TO THE MEDICAID STATE PLAN AND SHALL APPLY FOR ANY NECESSARY WAIVERS AND APPROVALS FROM THE FEDERAL CENTERS FOR MEDICARE AND MEDICAID SERVICES TO IMPLEMENT THE MICHIGAN ESTATE RECOVERY PROGRAM. THE DEPARTMENT SHALL SEEK APPROVAL FROM THE FEDERAL CENTERS FOR MEDICARE AND MEDICAID REGARDING ALL OF THE FOLLOWING:

(A) WHICH MEDICAL SERVICES ARE SUBJECT TO ESTATE RECOVERY UNDER SECTION 1917(B)(1)(B)(*i*) AND (*ii*) OF TITLE XIX.

(B) WHICH RECIPIENTS OF MEDICAL ASSISTANCE ARE SUBJECT TO

ESTATE RECOVERY UNDER SECTION 1917(A) AND (B) OF TITLE XIX.

(C) UNDER WHAT CIRCUMSTANCES THE PROGRAM SHALL PURSUE RECOVERY FROM THE ESTATES OF SPOUSES OF RECIPIENTS OF MEDICAL ASSISTANCE WHO ARE SUBJECT TO ESTATE RECOVERY UNDER SECTION 1917(B)(2) OF TITLE XIX.

(D) THE MAXIMUM DIVESTITURE LOOK BACK PERIOD FOR ASSETS THAT ARE SUBJECT TO ESTATE RECOVERY UNDER SECTION 1917(C) OF TITLE XIX, INCLUDING ASSETS PLACED IN TRUSTS BY THE MEDICAL ASSISTANCE RECIPIENT AND ARE TRANSFERRED FOR LESS THAN FAIR MARKET VALUE.

(E) WHAT ACTIONS MAY BE TAKEN TO OBTAIN FUNDS FROM THE ESTATES OF RECIPIENTS SUBJECT TO RECOVERY UNDER SECTION 1917 OF TITLE XIX, INCLUDING NOTICE AND HEARING PROCEDURES THAT MAY BE PURSUED TO CONTEST ACTIONS TAKEN UNDER THE MEDICAID ESTATE RECOVERY PROGRAM.

(F) UNDER WHAT CIRCUMSTANCES RECIPIENTS WILL BE EXEMPT FROM THE MEDICAID ESTATE RECOVERY PROGRAM BECAUSE OF A HARDSHIP. THE DEPARTMENT SHALL DEVELOP A DEFINITION OF HARDSHIP ACCORDING TO SECTION 1917(B)(3) OF TITLE XIX. THE PROVISIONS OF SECTION 1396P(B)(3) OF TITLE XIX SHALL BE IMPLEMENTED TO ENSURE THAT THE HEIRS OF PERSONS SUBJECT TO THE MEDICAID ESTATE RECOVERY PROGRAM WILL NOT BE UNREASONABLY HARMED BY THE PROVISIONS OF THIS PROGRAM.

(G) THE DEPARTMENT SHALL NOT SEEK MEDICAID ESTATE RECOVERY IF THE COSTS OF RECOVERY EXCEED THE AMOUNT OF RECOVERY AVAILABLE OR IF THE RECOVERY IS NOT IN THE BEST ECONOMIC INTEREST OF THE STATE.

(4) THE DEPARTMENT SHALL NOT IMPLEMENT A MEDICAID ESTATE RECOVERY PROGRAM UNTIL APPROVAL BY THE FEDERAL GOVERNMENT IS OBTAINED.

SEC. 112H. FOR THE PURPOSES OF SECTIONS 112G TO 112J, "ESTATE"

AND "PROPERTY" MEAN THOSE TERMS AS DEFINED IN SECTIONS 1104 AND 1106 OF THE ESTATES AND PROTECTED INDIVIDUALS CODE OF 1998, 1998 PA 386, MCL 700.1104 AND 700.1106.

SEC. 112I. REVENUE COLLECTED THROUGH MEDICAID ESTATE RECOVERY ACTIVITIES SHALL BE USED TO FUND THE ACTIVITIES OF THE MEDICAID ESTATE RECOVERY PROGRAM. ANY REMAINING BALANCES SHALL BE TREATED AS AN EXPENDITURE CREDIT IN THE MEDICAL SERVICES APPROPRIATION UNIT OF THE ANNUAL DEPARTMENT OF COMMUNITY HEALTH APPROPRIATION.

SEC. 112J. THE DEPARTMENT MAY PROMULGATE RULES FOR THE MEDICAID ESTATE RECOVERY PROGRAM ACCORDING TO THE ADMINISTRATIVE PROCEDURES ACT OF 1969, 1969 PA 306, MCL 24.201 TO 24.328.

Enacting section 1. This amendatory act does not take effect unless all of the following bills of the 93rd Legislature are enacted into law:

(a) Senate Bill No. 821.

(b) Senate Bill No. 822.

SENATE BILL No. 822

October 19, 2005, Introduced by Senator SWITALSKI and referred to the Committee on Appropriations.

A bill to amend 1998 PA 386, entitled

"Estates and protected individuals code,"

by amending section 3805 (MCL 700.3805), as amended by 2000 PA 177.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 3805. (1) If the applicable estate property is insufficient to pay all claims and allowances in full, the personal representative shall make payment in the following order of priority:

(a) Costs and expenses of administration.

(b) Reasonable funeral and burial expenses.

(c) Homestead allowance.

(d) Family allowance.

(e) Exempt property.

SENATE BILL No. 822

(f) Debts and taxes with priority under federal law, **INCLUDING, BUT NOT LIMITED TO, MEDICAL ASSISTANCE PAYMENTS THAT ARE SUBJECT TO ADJUSTMENT OR RECOVERY FROM AN ESTATE UNDER SECTION 1917 OF THE SOCIAL SECURITY ACT, 42 USC 1396P.**

(g) Reasonable and necessary medical and hospital expenses of the decedent's last illness, including a compensation of persons attending the decedent.

(h) Debts and taxes with priority under other laws of this state.

(i) All other claims.

(2) A preference shall not be given in the payment of a claim over another claim of the same class, and a claim due and payable is not entitled to a preference over a claim not due.

(3) If there are insufficient assets to pay all claims in full or to satisfy homestead allowance, family allowance, and exempt property, the personal representative shall certify the amount and nature of the deficiency to the trustee of a trust described in section 7501(1) for payment by the trustee in accordance with section 7502. If the personal representative is aware of other nonprobate transfers that may be liable for claims and allowances, then, unless the will provides otherwise, the personal representative shall proceed to collect the deficiency in a manner reasonable under the circumstances so that each nonprobate transfer, including those made under a trust described in section 7501(1), bears a proportionate share or equitable share of the total burden.

Enacting section 1. This amendatory act does not take effect

unless all of the following bills of the 93rd Legislature are enacted into law:

(a) Senate Bill No. 820.

(b) Senate Bill No. 821.

SENATE BILL No. 822

October 19, 2005, Introduced by Senator SWITALSKI and referred to the Committee on Appropriations.

A bill to amend 1998 PA 386, entitled

"Estates and protected individuals code,"

by amending section 3805 (MCL 700.3805), as amended by 2000 PA 177.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 3805. (1) If the applicable estate property is insufficient to pay all claims and allowances in full, the personal representative shall make payment in the following order of priority:

(a) Costs and expenses of administration.

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(d) Family allowance.

(e) Exempt property.

SENATE BILL No. 822

(f) Debts and taxes with priority under federal law, **INCLUDING, BUT NOT LIMITED TO, MEDICAL ASSISTANCE PAYMENTS THAT ARE SUBJECT TO ADJUSTMENT OR RECOVERY FROM AN ESTATE UNDER SECTION 1917 OF THE SOCIAL SECURITY ACT, 42 USC 1396P.**

(g) Reasonable and necessary medical and hospital expenses of the decedent's last illness, including a compensation of persons attending the decedent.

(h) Debts and taxes with priority under other laws of this state.

(i) All other claims.

(2) A preference shall not be given in the payment of a claim over another claim of the same class, and a claim due and payable is not entitled to a preference over a claim not due.

(3) If there are insufficient assets to pay all claims in full or to satisfy homestead allowance, family allowance, and exempt property, the personal representative shall certify the amount and nature of the deficiency to the trustee of a trust described in section 7501(1) for payment by the trustee in accordance with section 7502. If the personal representative is aware of other nonprobate transfers that may be liable for claims and allowances, then, unless the will provides otherwise, the personal representative shall proceed to collect the deficiency in a manner reasonable under the circumstances so that each nonprobate transfer, including those made under a trust described in section 7501(1), bears a proportionate share or equitable share of the total burden.

Enacting section 1. This amendatory act does not take effect

unless all of the following bills of the 93rd Legislature are enacted into law:

(a) Senate Bill No. 820.

(b) Senate Bill No. 821.

HOUSE BILL No. 5389

November 1, 2005, Introduced by Reps. Shaffer, Amos, Vander Veen, Caul, Proos, LaJoy, Marleau, Nitz, Pearce, Zelenko, Byrnes, Alma Smith, Farrah, Pastor, Casperson, Kahn, Kooiman, Palsrok, Newell, Ball, Green, Stahl, Robertson, Wojno, Gillard, Clack, Bennett, Mortimer, Hansen, Sheen, Farhat, Sak, Emmons, Vagnozzi, Donigan, Hune, Garfield, Polidori, Spade, Byrum, Gosselin and Gleason and referred to the Committee on Senior Health, Security, and Retirement.

A bill to amend 1939 PA 280, entitled

"The social welfare act,"

(MCL 400.1 to 400.119b) by adding section 109i.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

SEC. 109I. (1) THE DIRECTOR OF THE DEPARTMENT OF COMMUNITY HEALTH SHALL DESIGNATE AND MAINTAIN LOCALLY AND REGIONALLY BASED SINGLE POINTS OF ENTRY FOR LONG-TERM CARE THAT SHALL SERVE AS VISIBLE AND EFFECTIVE ACCESS POINTS FOR INDIVIDUALS SEEKING LONG-TERM CARE AND THAT SHALL PROMOTE CONSUMER CHOICE OF LONG-TERM CARE OPTIONS.

(2) THE DEPARTMENT OF COMMUNITY HEALTH SHALL MONITOR SINGLE POINTS OF ENTRY FOR LONG-TERM CARE FOR, AT A MINIMUM, ALL OF THE FOLLOWING:

HOUSE BILL No. 5389

(A) TO PREVENT BIAS IN ELIGIBILITY DETERMINATION AND TO PREVENT THE PROMOTION OF SPECIFIC SERVICES TO THE DETRIMENT OF CONSUMER CHOICE AND CONTROL.

(B) TO REVIEW ALL CONSUMER ASSESSMENTS AND CARE PLANS TO ENSURE CONSISTENCY, QUALITY, AND ADHERENCE TO THE PRINCIPLES OF PERSON-CENTERED PLANNING AND OTHER CRITERIA ESTABLISHED BY THE DEPARTMENT OF COMMUNITY HEALTH.

(C) TO ASSURE THE PROVISION OF QUALITY ASSISTANCE AND SUPPORTS.

(D) TO ASSURE THAT QUALITY ASSISTANCE AND SUPPORTS ARE PROVIDED TO APPLICANTS AND CONSUMERS IN A MANNER CONSISTENT WITH THEIR CULTURAL NORMS, LANGUAGE OF PREFERENCE, AND MEANS OF COMMUNICATION.

(E) TO ASSURE CONSUMER ACCESS TO AN INDEPENDENT CONSUMER ADVOCATE.

(3) THE DEPARTMENT OF COMMUNITY HEALTH SHALL ESTABLISH AND PUBLICIZE A TOLL-FREE TELEPHONE NUMBER FOR AREAS OF THE STATE IN WHICH A SINGLE POINT OF ENTRY IS OPERATIONAL AS A MEANS OF ACCESS.

(4) THE DEPARTMENT OF COMMUNITY HEALTH SHALL PROMULGATE RULES ESTABLISHING STANDARDS OF REASONABLE PROMPTNESS FOR DELIVERY OF SINGLE POINT OF ENTRY SERVICES AND FOR LONG-TERM CARE SERVICES AND SUPPORTS.

(5) THE DEPARTMENT OF COMMUNITY HEALTH SHALL REQUIRE THAT SINGLE POINTS OF ENTRY FOR LONG-TERM CARE PERFORM ALL OF THE FOLLOWING DUTIES AND RESPONSIBILITIES:

(A) PROVIDE CONSUMERS AND ANY OTHERS WITH INFORMATION ON AND REFERRAL TO ALL LONG-TERM CARE OPTIONS, SERVICES, AND SUPPORTS.

(B) FACILITATE MOVEMENT BETWEEN SUPPORTS, SERVICES, AND SETTINGS IN AN ADEQUATE AND TIMELY MANNER THAT ASSURES THE SAFETY AND WELL-BEING OF THE CONSUMER.

(C) ASSESS A CONSUMER'S ELIGIBILITY FOR ALL MEDICAID LONG-TERM CARE PROGRAMS UTILIZING A COMPREHENSIVE LEVEL OF CARE TOOL.

(D) ASSIST CONSUMERS TO OBTAIN A FINANCIAL DETERMINATION OF ELIGIBILITY FOR PUBLICLY FUNDED LONG-TERM CARE PROGRAMS.

(E) ASSIST CONSUMERS TO DEVELOP THEIR LONG-TERM CARE SUPPORT PLANS THROUGH A PERSON-CENTERED PLANNING PROCESS.

(F) AUTHORIZE AND, IF REQUESTED, ARRANGE FOR NEEDED TRANSITION SERVICES FOR CONSUMERS LIVING IN NURSING FACILITIES.

(G) WORK WITH CONSUMERS IN ACUTE AND PRIMARY CARE SETTINGS AS WELL AS COMMUNITY SETTINGS TO ASSURE THAT THEY ARE PRESENTED WITH THE FULL ARRAY OF LONG-TERM CARE OPTIONS.

(H) REEVALUATE CONSUMERS' NEED AND ELIGIBILITY FOR LONG-TERM CARE SERVICES ON A REGULAR BASIS.

(I) PERFORM THE AUTHORIZATION OF MEDICAID SERVICES IDENTIFIED IN THE CONSUMER'S CARE SUPPORTS PLAN.

(6) THE DEPARTMENT OF COMMUNITY HEALTH SHALL, IN CONSULTATION WITH CONSUMERS, STAKEHOLDERS, AND MEMBERS OF THE PUBLIC, ESTABLISH CRITERIA FOR DESIGNATION OF LOCAL OR REGIONAL SINGLE POINTS OF ENTRY FOR LONG-TERM CARE. THE CRITERIA SHALL ENSURE THAT SINGLE POINTS OF ENTRY FOR LONG-TERM CARE MEET ALL OF THE FOLLOWING CRITERIA:

(A) ARE NOT A PROVIDER OF DIRECT MEDICAID SERVICES. FOR THE PURPOSES OF THIS SECTION, CARE MANAGEMENT AND SUPPORTS COORDINATION ARE NOT CONSIDERED DIRECT MEDICAID SERVICES.

(B) ARE FREE FROM ALL LEGAL AND FINANCIAL CONFLICTS OF INTEREST WITH PROVIDERS OF MEDICAID SERVICES.

(C) ARE CAPABLE OF SERVING AS THE FOCAL POINT FOR ALL INDIVIDUALS SEEKING INFORMATION ABOUT LONG-TERM CARE IN THEIR REGION, INCLUDING INDIVIDUALS WHO WILL PAY PRIVATELY FOR SERVICES.

(D) ARE CAPABLE OF PERFORMING CONSUMER DATA COLLECTION, MANAGEMENT, AND REPORTING IN COMPLIANCE WITH STATE REQUIREMENTS.

(E) HAVE QUALITY ASSURANCE STANDARDS AND PROCEDURES THAT MEASURE CONSUMER SATISFACTION, MONITOR CONSUMER OUTCOMES, AND TRIGGER CHANGES TO THE CARE AND SUPPORTS PLAN.

(F) MAINTAIN AN INTERNAL AND EXTERNAL APPEALS PROCESS THAT PROVIDES FOR A REVIEW OF INDIVIDUAL DECISIONS.

(G) COMPLETE AN INITIAL EVALUATION OF APPLICANTS FOR LONG-TERM CARE WITHIN 2 BUSINESS DAYS AFTER CONTACT BY THE INDIVIDUAL OR HIS OR HER LEGAL REPRESENTATIVE.

(H) IN PARTNERSHIP WITH THE CONSUMER, DEVELOP A PRELIMINARY PERSON-CENTERED PLAN WITHIN 7 DAYS AFTER THE APPLICANT IS FOUND TO BE ELIGIBLE FOR SERVICES.

(7) SINGLE POINTS OF ENTRY FOR LONG-TERM CARE THAT FAIL TO MEET THE CRITERIA DESCRIBED IN THIS SECTION, AND OTHER FISCAL AND PERFORMANCE STANDARDS AS DETERMINED BY THE DEPARTMENT OF COMMUNITY HEALTH, MAY BE SUBJECT TO TERMINATION AS A DESIGNATED SINGLE POINT OF ENTRY BY THE DEPARTMENT OF COMMUNITY HEALTH.

(8) THE DEPARTMENT OF COMMUNITY HEALTH SHALL PROMULGATE RULES ESTABLISHING TIMELINES OF WITHIN 2 BUSINESS DAYS OR LESS FOR THE COMPLETION OF INITIAL EVALUATIONS OF INDIVIDUALS IN URGENT OR EMERGENT SITUATIONS AND RULES ESTABLISHING TIMELINES FOR COMPLETION

OF A FINAL EVALUATION AND ASSESSMENT FOR ALL INDIVIDUALS. TIMELINES ESTABLISHED UNDER THIS SUBSECTION SHALL NOT BE LONGER THAN 2 WEEKS FROM INITIAL CONTACT WITH THE INDIVIDUAL.

(9) THE DEPARTMENT OF COMMUNITY HEALTH SHALL SOLICIT PROPOSALS FROM ENTITIES SEEKING DESIGNATION AS A SINGLE POINT OF ENTRY AND SHALL DESIGNATE AT LEAST 3 AGENCIES TO SERVE AS A SINGLE POINT OF ENTRY IN AT LEAST 3 SEPARATE AREAS OF THE STATE. THERE SHALL BE NO MORE THAN 1 SINGLE POINT OF ENTRY IN EACH DESIGNATED REGION. AN AGENCY DESIGNATED BY THE DEPARTMENT OF COMMUNITY HEALTH UNDER THIS SUBSECTION SHALL SERVE AS A SINGLE POINT OF ENTRY FOR AN INITIAL PERIOD OF 3 YEARS, SUBJECT TO THE PROVISIONS OF SUBSECTION (7).

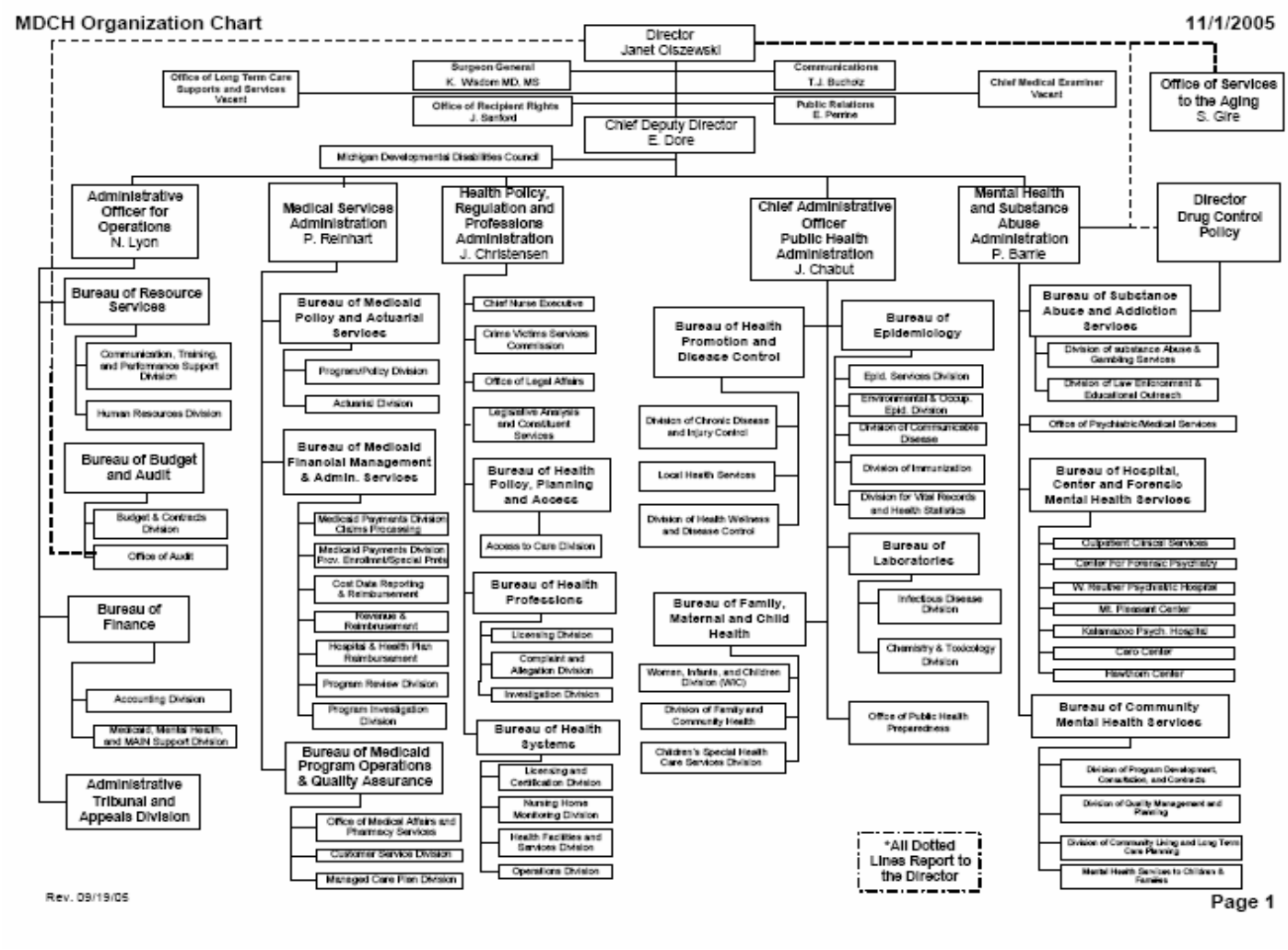
(10) THE DEPARTMENT OF COMMUNITY HEALTH SHALL EVALUATE THE PERFORMANCE OF THE AGENCIES DESIGNATED AS SINGLE POINTS OF ENTRY UNDER THIS SECTION ON AN ANNUAL BASIS AND SHALL MAKE ANY REPORT OR RECOMMENDATION FOR IMPROVEMENT REGARDING THE SINGLE POINT OF ENTRY SYSTEM AVAILABLE TO THE LEGISLATURE AND THE PUBLIC.

(11) NOT LATER THAN OCTOBER 1, 2008, THE DEPARTMENT OF COMMUNITY HEALTH SHALL DESIGNATE AN AGENCY TO SERVE AS A SINGLE POINT OF ENTRY IN EACH REGION OF THE STATE. NOTHING IN THIS SECTION PROHIBITS THE DEPARTMENT OF COMMUNITY HEALTH FROM DESIGNATING SINGLE POINTS OF ENTRY THROUGHOUT THE ENTIRE STATE BEFORE OCTOBER 1, 2008.

(12) THE DEPARTMENT SHALL PROMULGATE RULES TO IMPLEMENT THE PROVISIONS OF THIS SECTION NOT LATER THAN 180 DAYS AFTER THE EFFECTIVE DATE OF THE AMENDATORY ACT THAT ADDED THIS SECTION.

APPENDICES

ORG CHARTS


MDCH Organization Chart
11/1/2005
Director
Janet Olszewski
Office of Long Term Care Supports and Services
Vacant
Surgeon General
K. Wisdom MD, MS
Office of Recipient Rights
J. Sanford
Communications
T.J. Bucholz
Public Relations
E. Perrine
Chief Medical Examiner
Vacant
Office of Services to the Aging
S. Gire
Chief Deputy Director
E. Dore
Michigan Developmental Disabilities Council
Administrative Officer for Operations
N. Lyon
Medical Services Administration
P. Reinhart
Health Policy, Regulation and Professions Administration
J. Christensen
Chief Administrative Officer Public Health Administration
J. Chabut
Mental Health and Substance Abuse Administration
P. Barrie
Director Drug Control Policy
Bureau of Resource Services
Communication, Training, and Performance Support Division
Human Resources Division
Bureau of Budget and Audit
Budget & Contracts Division
Office of Audit
Bureau of Finance
Accounting Division
Medicaid, Mental Health, and MAIN Support Division
Administrative Tribunal and Appeals Division
Bureau of Medicaid Policy and Actuarial Services
Program/Policy Division
Actuarial Division
Bureau of Medicaid Financial Management & Admin. Services
Medicaid Payments Division Claims Processing
Medicaid Payments Division Prov. Enrollment/Special Pmts
Cost Data Reporting & Reimbursement
Revenue & Reimbursement
Hospital & Health Plan Reimbursement
Program Review Division
Program Investigation Division
Bureau of Medicaid Program Operations & Quality Assurance
Office of Medical Affairs and Pharmacy Services
Customer Service Division
Managed Care Plan Division
Chief Nurse Executive
Crime Victims Services Commission
Office of Legal Affairs
Legislative Analysis and Constituent Services
Bureau of Health Policy, Planning and Access
Access to Care Division
Bureau of Health Professions
Licensing Division
Complaint and Allegation Division
Investigation Division
Bureau of Health Systems
Licensing and Certification Division
Nursing Home Monitoring Division
Health Facilities and Services Division
Operations Division
Bureau of Health Promotion and Disease Control
Division of Chronic Disease and Injury Control
Local Health Services
Division of Health Wellness and Disease Control
Bureau of Family, Maternal and Child Health
Women, Infants, and Children Division (WIC)
Division of Family and Community Health
Children's Special Health Care Services Division
Bureau of Epidemiology
Epid. Services Division
Environmental & Occup. Epid. Division
Division of Communicable Disease
Division of Immunization
Division for Vital Records and Health Statistics
Bureau of Laboratories
Infectious Disease Division
Chemistry & Toxicology Division
Office of Public Health Preparedness
*All Dotted Lines Report to the Director
Bureau of Substance Abuse and Addiction Services
Division of Substance Abuse & Gambling Services
Division of Law Enforcement & Educational Outreach
Office of Psychiatric/Medical Services
Bureau of Hospital, Center and Forensic Mental Health Services
Outpatient Clinical Services
Center for Forensic Psychiatry
W. Reuther Psychiatric Hospital
Mt. Pleasant Center
Kalamazoo Psych. Hospital
Caro Center
Hawthorn Center
Bureau of Community Mental Health Services
Division of Program Development, Consultation, and Contracts
Division of Quality Management and Planning
Division of Community Living and Long Term Care Planning
Mental Health Services to Children & Families
Rev. 09/19/05
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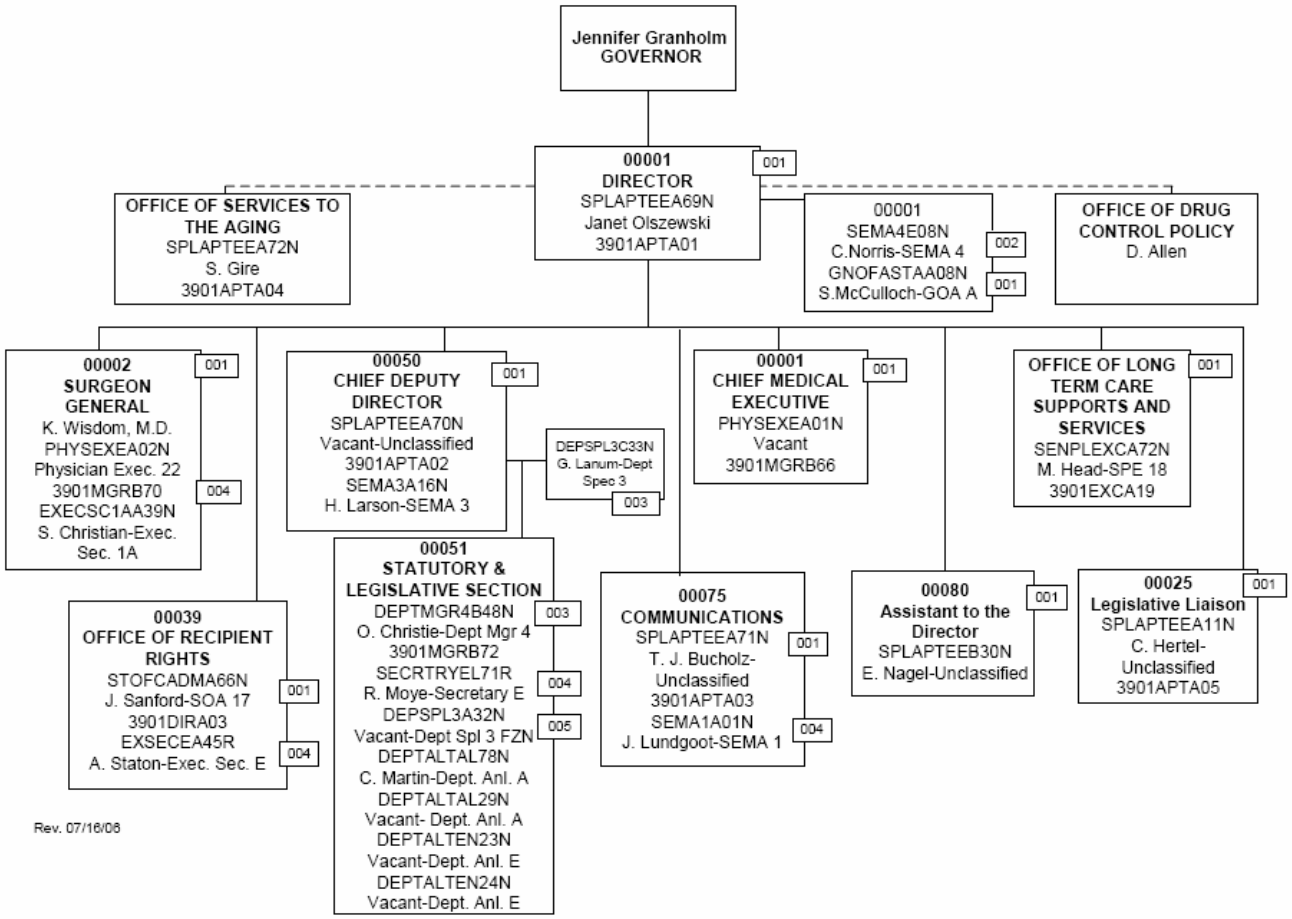
Jennifer Granholm
GOVERNOR
00001
DIRECTOR
SPLAPTEEA69N
Janet Olszewski
3901APTA01
001
OFFICE OF SERVICES TO THE AGING
SPLAPTEEA72N
S. Gire
3901APTA04
00001
SEMA4E08N
C.Norris-SEMA 4
002
GNOFASTAA08N
S.McCulloch-GOA A
001
OFFICE OF DRUG CONTROL POLICY
D. Allen
00002
SURGEON GENERAL
K. Wisdom, M.D.
PHYSEXEA02N
Physician Exec. 22
3901MGRB70
004
EXECSC1AA39N
S. Christian-Exec. Sec. 1A
00050
CHIEF DEPUTY DIRECTOR
SPLAPTEEA70N
Vacant-Unclassified
3901APTA02
SEMA3A16N
H. Larson-SEMA 3
DEPSPL3C33N
G. Lanum-Dept Spec 3
003
00001
CHIEF MEDICAL EXECUTIVE
PHYSEXEA01N
Vacant
3901MGRB66
OFFICE OF LONG TERM CARE SUPPORTS AND SERVICES
SENPLEXCA72N
M. Head-SPE 18
3901EXCA19
00039
OFFICE OF RECIPIENT RIGHTS
STOFCADMA66N
J. Sanford-SOA 17
3901DIRA03
EXSECEA45R
A. Staton-Exec. Sec. E
00051
STATUTORY & LEGISLATIVE SECTION
DEPTMGR4B48N
O. Christie-Dept Mgr 4
3901MGRB72
SECRTRYEL71R
R. Moye-Secretary E
DEPSPL3A32N
Vacant-Dept Spl 3 FZN
DEPTALTAL78N
C. Martin-Dept. Anl. A
DEPTALTAL29N
Vacant- Dept. Anl. A
DEPTALTEN23N
Vacant-Dept. Anl. E
DEPTALTEN24N
Vacant-Dept. Anl. E
00075
COMMUNICATIONS
SPLAPTEEA71N
T. J. Bucholz-Unclassified
3901APTA03
SEMA1A01N
J. Lundgoot-SEMA 1
00080
Assistant to the Director
SPLAPTEEB30N
E. Nagel-Unclassified
00025
Legislative Liaison
SPLAPTEEA11N
C. Hertel-Unclassified
3901APTA05
Rev. 07/16/06

OPEN MEETINGS ACT

OPEN MEETINGS ACT
Act 267 of 1976

AN ACT to require certain meetings of certain public bodies to be open to the public; to require notice and the keeping of minutes of meetings; to provide for enforcement; to provide for invalidation of governmental decisions under certain circumstances; to provide penalties; and to repeal certain acts and parts of acts.

History: 1976, Act 267, Eff. Mar. 31, 1977.

The People of the State of Michigan enact:

15.261 Short title; effect of act on certain charter provisions, ordinances, or resolutions.

Sec. 1. (1) This act shall be known and may be cited as the "Open meetings act".

(2) This act shall supersede all local charter provisions, ordinances, or resolutions which relate to requirements for meetings of local public bodies to be open to the public.

(3) After the effective date of this act, nothing in this act shall prohibit a public body from adopting an ordinance, resolution, rule, or charter provision which would require a greater degree of openness relative to meetings of public bodies than the standards provided for in this act.

History: 1976, Act 267, Eff. Mar. 31, 1977.

15.262 Definitions.

Sec. 2. As used in this act:

(a) "Public body" means any state or local legislative or governing body, including a board, commission, committee, subcommittee, authority, or council, that is empowered by state constitution, statute, charter, ordinance, resolution, or rule to exercise governmental or proprietary authority or perform a governmental or proprietary function; a lessee of such a body performing an essential public purpose and function pursuant to the lease agreement; or the board of a nonprofit corporation formed by a city under section 4o of the home rule city act, 1909 PA 279, MCL 117.4o.

(b) "Meeting" means the convening of a public body at which a quorum is present for the purpose of deliberating toward or rendering a decision on a public policy, or any meeting of the board of a nonprofit corporation formed by a city under section 4o of the home rule city act, 1909 PA 279, MCL 117.4o.

(c) "Closed session" means a meeting or part of a meeting of a public body that is closed to the public.

(d) "Decision" means a determination, action, vote, or disposition upon a motion, proposal, recommendation, resolution, order, ordinance, bill, or measure on which a vote by members of a public body is required and by which a public body effectuates or formulates public policy.

History: 1976, Act 267, Eff. Mar. 31, 1977;—Am. 2001, Act 38, Imd. Eff. July 11, 2001.

15.263 Meetings, decisions, and deliberations of public body; requirements; attending or addressing meeting of public body; tape-recording, videotaping, broadcasting, and telecasting proceedings; rules and regulations; exclusion from meeting; exemptions.

Sec. 3. (1) All meetings of a public body shall be open to the public and shall be held in a place available to the general public. All persons shall be permitted to attend any meeting except as otherwise provided in this act. The right of a person to attend a meeting of a public body includes the right to tape-record, to videotape, to broadcast live on radio, and to telecast live on television the proceedings of a public body at a public meeting. The exercise of this right shall not be dependent upon the prior approval of the public body. However, a public body may establish reasonable rules and regulations in order to minimize the possibility of disrupting the meeting.

(2) All decisions of a public body shall be made at a meeting open to the public.

(3) All deliberations of a public body constituting a quorum of its members shall take place at a meeting open to the public except as provided in this section and sections 7 and 8.

(4) A person shall not be required as a condition of attendance at a meeting of a public body to register or otherwise provide his or her name or other information or otherwise to fulfill a condition precedent to attendance.

(5) A person shall be permitted to address a meeting of a public body under rules established and recorded by the public body. The legislature or a house of the legislature may provide by rule that the right to address may be limited to prescribed times at hearings and committee meetings only.

(6) A person shall not be excluded from a meeting otherwise open to the public except for a breach of the peace actually committed at the meeting.

(7) This act does not apply to the following public bodies only when deliberating the merits of a case:

(a) The worker's compensation appeal board created under the worker's disability compensation act of 1969, Act No. 317 of the Public Acts of 1969, as amended, being sections 418.101 to 418.941 of the Michigan Compiled Laws.

(b) The employment security board of review created under the Michigan employment security act, Act No. 1 of the Public Acts of the Extra Session of 1936, as amended, being sections 421.1 to 421.73 of the Michigan Compiled Laws.

(c) The state tenure commission created under Act No. 4 of the Public Acts of the Extra Session of 1937, as amended, being sections 38.71 to 38.191 of the Michigan Compiled Laws, when acting as a board of review from the decision of a controlling board.

(d) An arbitrator or arbitration panel appointed by the employment relations commission under the authority given the commission by Act No. 176 of the Public Acts of 1939, as amended, being sections 423.1 to 423.30 of the Michigan Compiled Laws.

(e) An arbitration panel selected under chapter 50A of the revised judicature act of 1961, Act No. 236 of the Public Acts of 1961, being sections 600.5040 to 600.5065 of the Michigan Compiled Laws.

(f) The Michigan public service commission created under Act No. 3 of the Public Acts of 1939, being sections 460.1 to 460.8 of the Michigan Compiled Laws.

(8) This act does not apply to an association of insurers created under the insurance code of 1956, Act No. 218 of the Public Acts of 1956, being sections 500.100 to 500.8302 of the Michigan Compiled Laws, or other association or facility formed under Act No. 218 of the Public Acts of 1956 as a nonprofit organization of insurer members.

(9) This act does not apply to a committee of a public body which adopts a nonpolicymaking resolution of tribute or memorial which resolution is not adopted at a meeting.

(10) This act does not apply to a meeting which is a social or chance gathering or conference not designed to avoid this act.

(11) This act shall not apply to the Michigan veterans' trust fund board of trustees or a county or district committee created under Act No. 9 of the Public Acts of the first extra session of 1946, being sections 35.601 to 35.610 of the Michigan Compiled Laws, when the board of trustees or county or district committee is deliberating the merits of an emergent need. A decision of the board of trustees or county or district committee made under this subsection shall be reconsidered by the board or committee at its next regular or special meeting consistent with the requirements of this act. "Emergent need" means a situation which the board of trustees, by rules promulgated under the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, as amended, being sections 24.201 to 24.328 of the Michigan Compiled Laws, determines requires immediate action.

History: 1976, Act 267, Eff. Mar. 31, 1977;—Am. 1981, Act 161, Imd. Eff. Nov. 30, 1981;—Am. 1986, Act 269, Imd. Eff. Dec. 19, 1986;—Am. 1988, Act 158, Imd. Eff. June 14, 1988;—Am. 1988, Act 278, Imd. Eff. July 27, 1988.

Administrative rules: R 35.621 of the Michigan Administrative Code.

15.264 Public notice of meetings generally; contents; places of posting.

Sec. 4. The following provisions shall apply with respect to public notice of meetings:

(a) A public notice shall always contain the name of the public body to which the notice applies, its telephone number if one exists, and its address.

(b) A public notice for a public body shall always be posted at its principal office and any other locations considered appropriate by the public body. Cable television may also be utilized for purposes of posting public notice.

(c) If a public body is a part of a state department, part of the legislative or judicial branch of state government, part of an institution of higher education, or part of a political subdivision or school district, a public notice shall also be posted in the respective principal office of the state department, the institution of higher education, clerk of the house of representatives, secretary of the state senate, clerk of the supreme court, or political subdivision or school district.

(d) If a public body does not have a principal office, the required public notice for a local public body shall be posted in the office of the county clerk in which the public body serves and the required public notice for a state public body shall be posted in the office of the secretary of state.

History: 1976, Act 267, Eff. Mar. 31, 1977;—Am. 1984, Act 87, Imd. Eff. Apr. 19, 1984.

15.265 Public notice of regular meetings, change in schedule of regular meetings, rescheduled regular meetings, or special meetings; time for posting; statement of date, time, and place; applicability of subsection (4); recess or adjournment; emergency

sessions; meeting in residential dwelling; notice.

Sec. 5. (1) A meeting of a public body shall not be held unless public notice is given as provided in this section by a person designated by the public body.

(2) For regular meetings of a public body, there shall be posted within 10 days after the first meeting of the public body in each calendar or fiscal year a public notice stating the dates, times, and places of its regular meetings.

(3) If there is a change in the schedule of regular meetings of a public body, there shall be posted within 3 days after the meeting at which the change is made, a public notice stating the new dates, times, and places of its regular meetings.

(4) Except as provided in this subsection or in subsection (6), for a rescheduled regular or a special meeting of a public body, a public notice stating the date, time, and place of the meeting shall be posted at least 18 hours before the meeting. The requirement of 18-hour notice shall not apply to special meetings of subcommittees of a public body or conference committees of the state legislature. A conference committee shall give a 6-hour notice. A second conference committee shall give a 1-hour notice. Notice of a conference committee meeting shall include written notice to each member of the conference committee and the majority and minority leader of each house indicating time and place of the meeting. This subsection does not apply to a public meeting held pursuant to section 4(2) to (5) of Act No. 239 of the Public Acts of 1955, as amended, being section 200.304 of the Michigan Compiled Laws.

(5) A meeting of a public body which is recessed for more than 36 hours shall be reconvened only after public notice, which is equivalent to that required under subsection (4), has been posted. If either house of the state legislature is adjourned or recessed for less than 18 hours, the notice provisions of subsection (4) are not applicable. Nothing in this section shall bar a public body from meeting in emergency session in the event of a severe and imminent threat to the health, safety, or welfare of the public when 2/3 of the members serving on the body decide that delay would be detrimental to efforts to lessen or respond to the threat.

(6) A meeting of a public body may only take place in a residential dwelling if a nonresidential building within the boundary of the local governmental unit or school system is not available without cost to the public body. For a meeting of a public body which is held in a residential dwelling, notice of the meeting shall be published as a display advertisement in a newspaper of general circulation in the city or township in which the meeting is to be held. The notice shall be published not less than 2 days before the day on which the meeting is held, and shall state the date, time, and place of the meeting. The notice, which shall be at the bottom of the display advertisement and which shall be set off in a conspicuous manner, shall include the following language: "This meeting is open to all members of the public under Michigan's open meetings act".

History: 1976, Act 267, Eff. Mar. 31, 1977;—Am. 1978, Act 256, Imd. Eff. June 21, 1978;—Am. 1982, Act 134, Imd. Eff. Apr. 22, 1982;—Am. 1984, Act 167, Imd. Eff. June 29, 1984.

15.266 Providing copies of public notice on written request; fee.

Sec. 6. (1) Upon the written request of an individual, organization, firm, or corporation, and upon the requesting party's payment of a yearly fee of not more than the reasonable estimated cost for printing and postage of such notices, a public body shall send to the requesting party by first class mail a copy of any notice required to be posted pursuant to section 5(2) to (5).

(2) Upon written request, a public body, at the same time a public notice of a meeting is posted pursuant to section 5, shall provide a copy of the public notice of that meeting to any newspaper published in the state and to any radio and television station located in the state, free of charge.

History: 1976, Act 267, Eff. Mar. 31, 1977.

15.267 Closed sessions; roll call vote; separate set of minutes.

Sec. 7. (1) A 2/3 roll call vote of members elected or appointed and serving is required to call a closed session, except for the closed sessions permitted under section 8(a), (b), (c), (g), (i), and (j). The roll call vote and the purpose or purposes for calling the closed session shall be entered into the minutes of the meeting at which the vote is taken.

(2) A separate set of minutes shall be taken by the clerk or the designated secretary of the public body at the closed session. These minutes shall be retained by the clerk of the public body, are not available to the public, and shall only be disclosed if required by a civil action filed under section 10, 11, or 13. These minutes may be destroyed 1 year and 1 day after approval of the minutes of the regular meeting at which the closed session was approved.

History: 1976, Act 267, Eff. Mar. 31, 1977;—Am. 1993, Act 81, Eff. Apr. 1, 1994;—Am. 1996, Act 464, Imd. Eff. Dec. 26, 1996.

15.268 Closed sessions; permissible purposes.

Sec. 8. A public body may meet in a closed session only for the following purposes:

(a) To consider the dismissal, suspension, or disciplining of, or to hear complaints or charges brought against, or to consider a periodic personnel evaluation of, a public officer, employee, staff member, or individual agent, if the named person requests a closed hearing. A person requesting a closed hearing may rescind the request at any time, in which case the matter at issue shall be considered after the rescission only in open sessions.

(b) To consider the dismissal, suspension, or disciplining of a student if the public body is part of the school district, intermediate school district, or institution of higher education that the student is attending, and if the student or the student's parent or guardian requests a closed hearing.

(c) For strategy and negotiation sessions connected with the negotiation of a collective bargaining agreement if either negotiating party requests a closed hearing.

(d) To consider the purchase or lease of real property up to the time an option to purchase or lease that real property is obtained.

(e) To consult with its attorney regarding trial or settlement strategy in connection with specific pending litigation, but only if an open meeting would have a detrimental financial effect on the litigating or settlement position of the public body.

(f) To review and consider the contents of an application for employment or appointment to a public office if the candidate requests that the application remain confidential. However, except as otherwise provided in this subdivision, all interviews by a public body for employment or appointment to a public office shall be held in an open meeting pursuant to this act. This subdivision does not apply to a public office described in subdivision (j).

(g) Partisan caucuses of members of the state legislature.

(h) To consider material exempt from discussion or disclosure by state or federal statute.

(i) For a compliance conference conducted by the department of commerce under section 16231 of the public health code, Act No. 368 of the Public Acts of 1978, being section 333.16231 of the Michigan Compiled Laws, before a complaint is issued.

(j) In the process of searching for and selecting a president of an institution of higher education established under section 4, 5, or 6 of article VIII of the state constitution of 1963, to review the specific contents of an application, to conduct an interview with a candidate, or to discuss the specific qualifications of a candidate if the particular process of searching for and selecting a president of an institution of higher education meets all of the following requirements:

(*i*) The search committee in the process, appointed by the governing board, consists of at least 1 student of the institution, 1 faculty member of the institution, 1 administrator of the institution, 1 alumnus of the institution, and 1 representative of the general public. The search committee also may include 1 or more members of the governing board of the institution, but the number shall not constitute a quorum of the governing board. However, the search committee shall not be constituted in such a way that any 1 of the groups described in this subparagraph constitutes a majority of the search committee.

(*ii*) After the search committee recommends the 5 final candidates, the governing board does not take a vote on a final selection for the president until at least 30 days after the 5 final candidates have been publicly identified by the search committee.

(*iii*) The deliberations and vote of the governing board of the institution on selecting the president take place in an open session of the governing board.

History: 1976, Act 267, Eff. Mar. 31, 1977;—Am. 1984, Act 202, Imd. Eff. July 3, 1984;—Am. 1993, Act 81, Eff. Apr. 1, 1994;—Am. 1996, Act 464, Imd. Eff. Dec. 26, 1996.

15.269 Minutes.

Sec. 9. (1) Each public body shall keep minutes of each meeting showing the date, time, place, members present, members absent, any decisions made at a meeting open to the public, and the purpose or purposes for which a closed session is held. The minutes shall include all roll call votes taken at the meeting. The public body shall make any corrections in the minutes at the next meeting after the meeting to which the minutes refer. The public body shall make corrected minutes available at or before the next subsequent meeting after correction. The corrected minutes shall show both the original entry and the correction.

(2) Minutes are public records open to public inspection, and a public body shall make the minutes available at the address designated on posted public notices pursuant to section 4. The public body shall make copies of the minutes available to the public at the reasonable estimated cost for printing and copying.

(3) A public body shall make proposed minutes available for public inspection within 8 business days after the meeting to which the minutes refer. The public body shall make approved minutes available for public

inspection within 5 business days after the meeting at which the minutes are approved by the public body.

(4) A public body shall not include in or with its minutes any personally identifiable information that, if released, would prevent the public body from complying with section 444 of subpart 4 of part C of the general education provisions act, 20 USC 1232g, commonly referred to as the family educational rights and privacy act of 1974.

History: 1976, Act 267, Eff. Mar. 31, 1977;—Am. 1982, Act 130, Imd. Eff. Apr. 20, 1982;—Am. 2004, Act 305, Imd. Eff. Aug. 11, 2004.

15.270 Decisions of public body; presumption; civil action to invalidate; jurisdiction; venue; reenactment of disputed decision.

Sec. 10. (1) Decisions of a public body shall be presumed to have been adopted in compliance with the requirements of this act. The attorney general, the prosecuting attorney of the county in which the public body serves, or any person may commence a civil action in the circuit court to challenge the validity of a decision of a public body made in violation of this act.

(2) A decision made by a public body may be invalidated if the public body has not complied with the requirements of section 3(1), (2), and (3) in making the decision or if failure to give notice in accordance with section 5 has interfered with substantial compliance with section 3(1), (2), and (3) and the court finds that the noncompliance or failure has impaired the rights of the public under this act.

(3) The circuit court shall not have jurisdiction to invalidate a decision of a public body for a violation of this act unless an action is commenced pursuant to this section within the following specified period of time:

(a) Within 60 days after the approved minutes are made available to the public by the public body except as otherwise provided in subdivision (b).

(b) If the decision involves the approval of contracts, the receipt or acceptance of bids, the making of assessments, the procedures pertaining to the issuance of bonds or other evidences of indebtedness, or the submission of a borrowing proposal to the electors, within 30 days after the approved minutes are made available to the public pursuant to that decision.

(4) Venue for an action under this section shall be any county in which a local public body serves or, if the decision of a state public body is at issue, in Ingham county.

(5) In any case where an action has been initiated to invalidate a decision of a public body on the ground that it was not taken in conformity with the requirements of this act, the public body may, without being deemed to make any admission contrary to its interest, reenact the disputed decision in conformity with this act. A decision reenacted in this manner shall be effective from the date of reenactment and shall not be declared invalid by reason of a deficiency in the procedure used for its initial enactment.

History: 1976, Act 267, Eff. Mar. 31, 1977.

15.271 Civil action to compel compliance or enjoin noncompliance; commencement; venue; security not required; commencement of action for mandamus; court costs and attorney fees.

Sec. 11. (1) If a public body is not complying with this act, the attorney general, prosecuting attorney of the county in which the public body serves, or a person may commence a civil action to compel compliance or to enjoin further noncompliance with this act.

(2) An action for injunctive relief against a local public body shall be commenced in the circuit court, and venue is proper in any county in which the public body serves. An action for an injunction against a state public body shall be commenced in the circuit court and venue is proper in any county in which the public body has its principal office, or in Ingham county. If a person commences an action for injunctive relief, that person shall not be required to post security as a condition for obtaining a preliminary injunction or a temporary restraining order.

(3) An action for mandamus against a public body under this act shall be commenced in the court of appeals.

(4) If a public body is not complying with this act, and a person commences a civil action against the public body for injunctive relief to compel compliance or to enjoin further noncompliance with the act and succeeds in obtaining relief in the action, the person shall recover court costs and actual attorney fees for the action.

History: 1976, Act 267, Eff. Mar. 31, 1977.

15.272 Violation as misdemeanor; penalty.

Sec. 12. (1) A public official who intentionally violates this act is guilty of a misdemeanor punishable by a fine of not more than $1,000.00.

(2) A public official who is convicted of intentionally violating a provision of this act for a second time within the same term shall be guilty of a misdemeanor and shall be fined not more than $2,000.00, or imprisoned for not more than 1 year, or both.

History: 1976, Act 267, Eff. Mar. 31, 1977.

15.273 Violation; liability.

Sec. 13. (1) A public official who intentionally violates this act shall be personally liable in a civil action for actual and exemplary damages of not more than $500.00 total, plus court costs and actual attorney fees to a person or group of persons bringing the action.

(2) Not more than 1 action under this section shall be brought against a public official for a single meeting. An action under this section shall be commenced within 180 days after the date of the violation which gives rise to the cause of action.

(3) An action for damages under this section may be joined with an action for injunctive or exemplary relief under section 11.

History: 1976, Act 267, Eff. Mar. 31, 1977.

15.273a Selection of president by governing board of higher education institution; violation; civil fine.

Sec. 13a. If the governing board of an institution of higher education established under section 4, 5, or 6 of article VIII of the state constitution of 1963 violates this act with respect to the process of selecting a president of the institution at any time after the recommendation of final candidates to the governing board, as described in section 8(j), the institution is responsible for the payment of a civil fine of not more than $500,000.00. This civil fine is in addition to any other remedy or penalty under this act. To the extent possible, any payment of fines imposed under this section shall be paid from funds allocated by the institution of higher education to pay for the travel and expenses of the members of the governing board.

History: Add. 1996, Act 464, Imd. Eff. Dec. 26, 1996.

15.274 Repeal of §§ 15.251 to 15.253.

Sec. 14. Act No. 261 of the Public Acts of 1968, being sections 15.251 to 15.253 of the Compiled Laws of 1970, is repealed.

History: 1976, Act 267, Eff. Mar. 31, 1977.

15.275 Effective date.

Sec. 15. This act shall take effect January 1, 1977.

History: 1976, Act 267, Eff. Mar. 31, 1977.

FREEDOM OF INFORMATION ACT

FREEDOM OF INFORMATION ACT
Act 442 of 1976

AN ACT to provide for public access to certain public records of public bodies; to permit certain fees; to prescribe the powers and duties of certain public officers and public bodies; to provide remedies and penalties; and to repeal certain acts and parts of acts.

History: 1976, Act 442, Eff. Apr. 13, 1977.

Popular name: Act 442

Popular name: FOIA

The People of the State of Michigan enact:

15.231 Short title; public policy.

Sec. 1. (1) This act shall be known and may be cited as the "freedom of information act".

(2) It is the public policy of this state that all persons, except those persons incarcerated in state or local correctional facilities, are entitled to full and complete information regarding the affairs of government and the official acts of those who represent them as public officials and public employees, consistent with this act. The people shall be informed so that they may fully participate in the democratic process.

History: 1976, Act 442, Eff. Apr. 13, 1977;—Am. 1994, Act 131, Imd. Eff. May 19, 1994;—Am. 1996, Act 553, Eff. Mar. 31, 1997;—Am. 1997, Act 6, Imd. Eff. May 16, 1997.

Popular name: Act 442

Popular name: FOIA

15.232 Definitions.

Sec. 2. As used in this act:

(a) "Field name" means the label or identification of an element of a computer data base that contains a specific item of information, and includes but is not limited to a subject heading such as a column header, data dictionary, or record layout.

(b) "FOIA coordinator" means either of the following:

(*i*) An individual who is a public body.

(*ii*) An individual designated by a public body in accordance with section 6 to accept and process requests for public records under this act.

(c) "Person" means an individual, corporation, limited liability company, partnership, firm, organization, association, governmental entity, or other legal entity. Person does not include an individual serving a sentence of imprisonment in a state or county correctional facility in this state or any other state, or in a federal correctional facility.

(d) "Public body" means any of the following:

(*i*) A state officer, employee, agency, department, division, bureau, board, commission, council, authority, or other body in the executive branch of the state government, but does not include the governor or lieutenant governor, the executive office of the governor or lieutenant governor, or employees thereof.

(*ii*) An agency, board, commission, or council in the legislative branch of the state government.

(*iii*) A county, city, township, village, intercounty, intercity, or regional governing body, council, school district, special district, or municipal corporation, or a board, department, commission, council, or agency thereof.

(*iv*) Any other body which is created by state or local authority or which is primarily funded by or through state or local authority.

(*v*) The judiciary, including the office of the county clerk and employees thereof when acting in the capacity of clerk to the circuit court, is not included in the definition of public body.

(e) "Public record" means a writing prepared, owned, used, in the possession of, or retained by a public body in the performance of an official function, from the time it is created. Public record does not include computer software. This act separates public records into the following 2 classes:

(*i*) Those that are exempt from disclosure under section 13.

(*ii*) All public records that are not exempt from disclosure under section 13 and which are subject to disclosure under this act.

(f) "Software" means a set of statements or instructions that when incorporated in a machine usable medium is capable of causing a machine or device having information processing capabilities to indicate, perform, or achieve a particular function, task, or result. Software does not include computer-stored

information or data, or a field name if disclosure of that field name does not violate a software license.

(g) "Unusual circumstances" means any 1 or a combination of the following, but only to the extent necessary for the proper processing of a request:

(*i*) The need to search for, collect, or appropriately examine or review a voluminous amount of separate and distinct public records pursuant to a single request.

(*ii*) The need to collect the requested public records from numerous field offices, facilities, or other establishments which are located apart from the particular office receiving or processing the request.

(h) "Writing" means handwriting, typewriting, printing, photostating, photographing, photocopying, and every other means of recording, and includes letters, words, pictures, sounds, or symbols, or combinations thereof, and papers, maps, magnetic or paper tapes, photographic films or prints, microfilm, microfiche, magnetic or punched cards, discs, drums, or other means of recording or retaining meaningful content.

(i) "Written request" means a writing that asks for information, and includes a writing transmitted by facsimile, electronic mail, or other electronic means.

History: 1976, Act 442, Eff. Apr. 13, 1977;—Am. 1994, Act 131, Imd. Eff. May 19, 1994;—Am. 1996, Act 553, Eff. Mar. 31, 1997.

Popular name: Act 442

Popular name: FOIA

15.233 Public records; right to inspect, copy, or receive; subscriptions; forwarding requests; file; inspection and examination; memoranda or abstracts; rules; compilation, summary, or report of information; creation of new public record; certified copies.

Sec. 3. (1) Except as expressly provided in section 13, upon providing a public body's FOIA coordinator with a written request that describes a public record sufficiently to enable the public body to find the public record, a person has a right to inspect, copy, or receive copies of the requested public record of the public body. A person has a right to subscribe to future issuances of public records that are created, issued, or disseminated on a regular basis. A subscription shall be valid for up to 6 months, at the request of the subscriber, and shall be renewable. An employee of a public body who receives a request for a public record shall promptly forward that request to the freedom of information act coordinator.

(2) A freedom of information act coordinator shall keep a copy of all written requests for public records on file for no less than 1 year.

(3) A public body shall furnish a requesting person a reasonable opportunity for inspection and examination of its public records, and shall furnish reasonable facilities for making memoranda or abstracts from its public records during the usual business hours. A public body may make reasonable rules necessary to protect its public records and to prevent excessive and unreasonable interference with the discharge of its functions. A public body shall protect public records from loss, unauthorized alteration, mutilation, or destruction.

(4) This act does not require a public body to make a compilation, summary, or report of information, except as required in section 11.

(5) This act does not require a public body to create a new public record, except as required in section 11, and to the extent required by this act for the furnishing of copies, or edited copies pursuant to section 14(1), of an already existing public record.

(6) The custodian of a public record shall, upon written request, furnish a requesting person a certified copy of a public record.

History: 1976, Act 442, Eff. Apr. 13, 1977;—Am. 1996, Act 553, Eff. Mar. 31, 1997.

Popular name: Act 442

Popular name: FOIA

15.234 Fee; waiver or reduction; affidavit; deposit; calculation of costs; limitation; provisions inapplicable to certain public records.

Sec. 4. (1) A public body may charge a fee for a public record search, the necessary copying of a public record for inspection, or for providing a copy of a public record. Subject to subsections (3) and (4), the fee shall be limited to actual mailing costs, and to the actual incremental cost of duplication or publication including labor, the cost of search, examination, review, and the deletion and separation of exempt from nonexempt information as provided in section 14. A search for a public record may be conducted or copies of public records may be furnished without charge or at a reduced charge if the public body determines that a waiver or reduction of the fee is in the public interest because searching for or furnishing copies of the public record can be considered as primarily benefiting the general public. A public record search shall be made and a copy of a public record shall be furnished without charge for the first $20.00 of the fee for each request to an

individual who is entitled to information under this act and who submits an affidavit stating that the individual is then receiving public assistance or, if not receiving public assistance, stating facts showing inability to pay the cost because of indigency.

(2) A public body may require at the time a request is made a good faith deposit from the person requesting the public record or series of public records, if the fee authorized under this section exceeds $50.00. The deposit shall not exceed 1/2 of the total fee.

(3) In calculating the cost of labor incurred in duplication and mailing and the cost of examination, review, separation, and deletion under subsection (1), a public body may not charge more than the hourly wage of the lowest paid public body employee capable of retrieving the information necessary to comply with a request under this act. Fees shall be uniform and not dependent upon the identity of the requesting person. A public body shall utilize the most economical means available for making copies of public records. A fee shall not be charged for the cost of search, examination, review, and the deletion and separation of exempt from nonexempt information as provided in section 14 unless failure to charge a fee would result in unreasonably high costs to the public body because of the nature of the request in the particular instance, and the public body specifically identifies the nature of these unreasonably high costs. A public body shall establish and publish procedures and guidelines to implement this subsection.

(4) This section does not apply to public records prepared under an act or statute specifically authorizing the sale of those public records to the public, or if the amount of the fee for providing a copy of the public record is otherwise specifically provided by an act or statute.

History: 1976, Act 442, Eff. Apr. 13, 1977;—Am. 1988, Act 99, Imd. Eff. Apr. 11, 1988;—Am. 1996, Act 553, Eff. Mar. 31, 1997.

Constitutionality: The disclosure of public records under the freedom of information act impartially to the general public for the incremental cost of creating the record is not a granting of credit by the state in aid of private persons and does not justify nondisclosure on the theory that the information is proprietary information belonging to a public body. Kestenbaum v. Michigan State University, 414 Mich. 510, 417 N.W.2d 1102 (1982).

Popular name: Act 442

Popular name: FOIA

15.235 Request to inspect or receive copy of public record; response to request; failure to respond; damages; contents of notice denying request; signing notice of denial; notice extending period of response; action by requesting person.

Sec. 5. (1) Except as provided in section 3, a person desiring to inspect or receive a copy of a public record shall make a written request for the public record to the FOIA coordinator of a public body. A written request made by facsimile, electronic mail, or other electronic transmission is not received by a public body's FOIA coordinator until 1 business day after the electronic transmission is made.

(2) Unless otherwise agreed to in writing by the person making the request, a public body shall respond to a request for a public record within 5 business days after the public body receives the request by doing 1 of the following:

(a) Granting the request.

(b) Issuing a written notice to the requesting person denying the request.

(c) Granting the request in part and issuing a written notice to the requesting person denying the request in part.

(d) Issuing a notice extending for not more than 10 business days the period during which the public body shall respond to the request. A public body shall not issue more than 1 notice of extension for a particular request.

(3) Failure to respond to a request pursuant to subsection (2) constitutes a public body's final determination to deny the request. In a circuit court action to compel a public body's disclosure of a public record under section 10, the circuit court shall assess damages against the public body pursuant to section 10(8) if the circuit court has done both of the following:

(a) Determined that the public body has not complied with subsection (2).

(b) Ordered the public body to disclose or provide copies of all or a portion of the public record.

(4) A written notice denying a request for a public record in whole or in part is a public body's final determination to deny the request or portion of that request. The written notice shall contain:

(a) An explanation of the basis under this act or other statute for the determination that the public record, or portion of that public record, is exempt from disclosure, if that is the reason for denying all or a portion of the request.

(b) A certificate that the public record does not exist under the name given by the requester or by another name reasonably known to the public body, if that is the reason for denying the request or a portion of the request.

(c) A description of a public record or information on a public record that is separated or deleted pursuant to section 14, if a separation or deletion is made.

(d) A full explanation of the requesting person's right to do either of the following:

(*i*) Submit to the head of the public body a written appeal that specifically states the word "appeal" and identifies the reason or reasons for reversal of the disclosure denial.

(*ii*) Seek judicial review of the denial under section 10.

(e) Notice of the right to receive attorneys' fees and damages as provided in section 10 if, after judicial review, the circuit court determines that the public body has not complied with this section and orders disclosure of all or a portion of a public record.

(5) The individual designated in section 6 as responsible for the denial of the request shall sign the written notice of denial.

(6) If a public body issues a notice extending the period for a response to the request, the notice shall specify the reasons for the extension and the date by which the public body will do 1 of the following:

(a) Grant the request.

(b) Issue a written notice to the requesting person denying the request.

(c) Grant the request in part and issue a written notice to the requesting person denying the request in part.

(7) If a public body makes a final determination to deny in whole or in part a request to inspect or receive a copy of a public record or portion of that public record, the requesting person may do either of the following:

(a) Appeal the denial to the head of the public body pursuant to section 10.

(b) Commence an action in circuit court, pursuant to section 10.

History: 1976, Act 442, Eff. Apr. 13, 1977;—Am. 1978, Act 329, Imd. Eff. July 11, 1978;—Am. 1996, Act 553, Eff. Mar. 31, 1997.

Compiler's note: In subsection (3), the reference to "section 10(8)" evidently should be a reference to " section 10(7)."

Popular name: Act 442

Popular name: FOIA

15.236 FOIA coordinator.

Sec. 6. (1) A public body that is a city, village, township, county, or state department, or under the control of a city, village, township, county, or state department, shall designate an individual as the public body's FOIA coordinator. The FOIA coordinator shall be responsible for accepting and processing requests for the public body's public records under this act and shall be responsible for approving a denial under section 5(4) and (5). In a county not having an executive form of government, the chairperson of the county board of commissioners is designated the FOIA coordinator for that county.

(2) For all other public bodies, the chief administrative officer of the respective public body is designated the public body's FOIA coordinator.

(3) An FOIA coordinator may designate another individual to act on his or her behalf in accepting and processing requests for the public body's public records, and in approving a denial under section 5(4) and (5).

History: 1976, Act 442, Eff. Apr. 13, 1977;—Am. 1996, Act 553, Eff. Mar. 31, 1997.

Popular name: Act 442

Popular name: FOIA

15.240 Options by requesting person; appeal; orders; venue; de novo proceeding; burden of proof; private view of public record; contempt; assignment of action or appeal for hearing, trial, or argument; attorneys' fees, costs, and disbursements; assessment of award; damages.

Sec. 10. (1) If a public body makes a final determination to deny all or a portion of a request, the requesting person may do 1 of the following at his or her option:

(a) Submit to the head of the public body a written appeal that specifically states the word "appeal" and identifies the reason or reasons for reversal of the denial.

(b) Commence an action in the circuit court to compel the public body's disclosure of the public records within 180 days after a public body's final determination to deny a request.

(2) Within 10 days after receiving a written appeal pursuant to subsection (1)(a), the head of a public body shall do 1 of the following:

(a) Reverse the disclosure denial.

(b) Issue a written notice to the requesting person upholding the disclosure denial.

(c) Reverse the disclosure denial in part and issue a written notice to the requesting person upholding the disclosure denial in part.

(d) Under unusual circumstances, issue a notice extending for not more than 10 business days the period during which the head of the public body shall respond to the written appeal. The head of a public body shall not issue more than 1 notice of extension for a particular written appeal.

(3) A board or commission that is the head of a public body is not considered to have received a written appeal under subsection (2) until the first regularly scheduled meeting of that board or commission following submission of the written appeal under subsection (1)(a). If the head of the public body fails to respond to a written appeal pursuant to subsection (2), or if the head of the public body upholds all or a portion of the disclosure denial that is the subject of the written appeal, the requesting person may seek judicial review of the nondisclosure by commencing an action in circuit court under subsection (1)(b).

(4) In an action commenced under subsection (1)(b), a court that determines a public record is not exempt from disclosure shall order the public body to cease withholding or to produce all or a portion of a public record wrongfully withheld, regardless of the location of the public record. The circuit court for the county in which the complainant resides or has his or her principal place of business, or the circuit court for the county in which the public record or an office of the public body is located has venue over the action. The court shall determine the matter de novo and the burden is on the public body to sustain its denial. The court, on its own motion, may view the public record in controversy in private before reaching a decision. Failure to comply with an order of the court may be punished as contempt of court.

(5) An action commenced under this section and an appeal from an action commenced under this section shall be assigned for hearing and trial or for argument at the earliest practicable date and expedited in every way.

(6) If a person asserting the right to inspect, copy, or receive a copy of all or a portion of a public record prevails in an action commenced under this section, the court shall award reasonable attorneys' fees, costs, and disbursements. If the person or public body prevails in part, the court may, in its discretion, award all or an appropriate portion of reasonable attorneys' fees, costs, and disbursements. The award shall be assessed against the public body liable for damages under subsection (7).

(7) If the circuit court determines in an action commenced under this section that the public body has arbitrarily and capriciously violated this act by refusal or delay in disclosing or providing copies of a public record, the court shall award, in addition to any actual or compensatory damages, punitive damages in the amount of $500.00 to the person seeking the right to inspect or receive a copy of a public record. The damages shall not be assessed against an individual, but shall be assessed against the next succeeding public body that is not an individual and that kept or maintained the public record as part of its public function.

History: 1976, Act 442, Eff. Apr. 13, 1977;—Am. 1978, Act 329, Imd. Eff. July 11, 1978;—Am. 1996, Act 553, Eff. Mar. 31, 1997.

Popular name: Act 442

Popular name: FOIA

15.241 Matters required to be published and made available by state agencies; form of publications; effect on person of matter not published and made available; exception; action to compel compliance by state agency; order; attorneys' fees, costs, and disbursements; jurisdiction; definitions.

Sec. 11. (1) A state agency shall publish and make available to the public all of the following:

(a) Final orders or decisions in contested cases and the records on which they were made.

(b) Promulgated rules.

(c) Other written statements which implement or interpret laws, rules, or policy, including but not limited to guidelines, manuals, and forms with instructions, adopted or used by the agency in the discharge of its functions.

(2) Publications may be in pamphlet, loose-leaf, or other appropriate form in printed, mimeographed, or other written matter.

(3) Except to the extent that a person has actual and timely notice of the terms thereof, a person shall not in any manner be required to resort to, or be adversely affected by, a matter required to be published and made available, if the matter is not so published and made available.

(4) This section does not apply to public records which are exempt from disclosure under section 13.

(5) A person may commence an action in the circuit court to compel a state agency to comply with this section. If the court determines that the state agency has failed to comply, the court shall order the state agency to comply and shall award reasonable attorneys' fees, costs, and disbursements to the person commencing the action. The circuit court for the county in which the state agency is located shall have jurisdiction to issue the order.

(6) As used in this section, "state agency", "contested case", and "rules" shall have the same meanings as ascribed to those terms in Act No. 306 of the Public Acts of 1969, as amended, being sections 24.201 to 24.315 of the Michigan Compiled Laws.

History: 1976, Act 442, Eff. Apr. 13, 1977.

Popular name: Act 442

Popular name: FOIA

15.243 Exemptions from disclosure; public body as school district or public school academy; withholding of information required by law or in possession of executive office.

Sec. 13. (1) A public body may exempt from disclosure as a public record under this act any of the following:

(a) Information of a personal nature if public disclosure of the information would constitute a clearly unwarranted invasion of an individual's privacy.

(b) Investigating records compiled for law enforcement purposes, but only to the extent that disclosure as a public record would do any of the following:

(*i*) Interfere with law enforcement proceedings.

(*ii*) Deprive a person of the right to a fair trial or impartial administrative adjudication.

(*iii*) Constitute an unwarranted invasion of personal privacy.

(*iv*) Disclose the identity of a confidential source, or if the record is compiled by a law enforcement agency in the course of a criminal investigation, disclose confidential information furnished only by a confidential source.

(*v*) Disclose law enforcement investigative techniques or procedures.

(*vi*) Endanger the life or physical safety of law enforcement personnel.

(c) A public record that if disclosed would prejudice a public body's ability to maintain the physical security of custodial or penal institutions occupied by persons arrested or convicted of a crime or admitted because of a mental disability, unless the public interest in disclosure under this act outweighs the public interest in nondisclosure.

(d) Records or information specifically described and exempted from disclosure by statute.

(e) A public record or information described in this section that is furnished by the public body originally compiling, preparing, or receiving the record or information to a public officer or public body in connection with the performance of the duties of that public officer or public body, if the considerations originally giving rise to the exempt nature of the public record remain applicable.

(f) Trade secrets or commercial or financial information voluntarily provided to an agency for use in developing governmental policy if:

(*i*) The information is submitted upon a promise of confidentiality by the public body.

(*ii*) The promise of confidentiality is authorized by the chief administrative officer of the public body or by an elected official at the time the promise is made.

(*iii*) A description of the information is recorded by the public body within a reasonable time after it has been submitted, maintained in a central place within the public body, and made available to a person upon request. This subdivision does not apply to information submitted as required by law or as a condition of receiving a governmental contract, license, or other benefit.

(g) Information or records subject to the attorney-client privilege.

(h) Information or records subject to the physician-patient privilege, the psychologist-patient privilege, the minister, priest, or Christian Science practitioner privilege, or other privilege recognized by statute or court rule.

(i) A bid or proposal by a person to enter into a contract or agreement, until the time for the public opening of bids or proposals, or if a public opening is not to be conducted, until the deadline for submission of bids or proposals has expired.

(j) Appraisals of real property to be acquired by the public body until either of the following occurs:

(*i*) An agreement is entered into.

(*ii*) Three years have elapsed since the making of the appraisal, unless litigation relative to the acquisition has not yet terminated.

(k) Test questions and answers, scoring keys, and other examination instruments or data used to administer a license, public employment, or academic examination, unless the public interest in disclosure under this act outweighs the public interest in nondisclosure.

(*l*) Medical, counseling, or psychological facts or evaluations concerning an individual if the individual's identity would be revealed by a disclosure of those facts or evaluation.

(m) Communications and notes within a public body or between public bodies of an advisory nature to the extent that they cover other than purely factual materials and are preliminary to a final agency determination of policy or action. This exemption does not apply unless the public body shows that in the particular instance the public interest in encouraging frank communication between officials and employees of public bodies clearly outweighs the public interest in disclosure. This exemption does not constitute an exemption under state law for purposes of section 8(h) of the open meetings act, 1976 PA 267, MCL 15.268. As used in this subdivision, "determination of policy or action" includes a determination relating to collective bargaining, unless the public record is otherwise required to be made available under 1947 PA 336, MCL 423.201 to 423.217.

(n) Records of law enforcement communication codes, or plans for deployment of law enforcement personnel, that if disclosed would prejudice a public body's ability to protect the public safety unless the public interest in disclosure under this act outweighs the public interest in nondisclosure in the particular instance.

(o) Information that would reveal the exact location of archaeological sites. The department of history, arts, and libraries may promulgate rules in accordance with the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, to provide for the disclosure of the location of archaeological sites for purposes relating to the preservation or scientific examination of sites.

(p) Testing data developed by a public body in determining whether bidders' products meet the specifications for purchase of those products by the public body, if disclosure of the data would reveal that only 1 bidder has met the specifications. This subdivision does not apply after 1 year has elapsed from the time the public body completes the testing.

(q) Academic transcripts of an institution of higher education established under section 5, 6, or 7 of article VIII of the state constitution of 1963, if the transcript pertains to a student who is delinquent in the payment of financial obligations to the institution.

(r) Records of a campaign committee including a committee that receives money from a state campaign fund.

(s) Unless the public interest in disclosure outweighs the public interest in nondisclosure in the particular instance, public records of a law enforcement agency, the release of which would do any of the following:

(*i*) Identify or provide a means of identifying an informant.

(*ii*) Identify or provide a means of identifying a law enforcement undercover officer or agent or a plain clothes officer as a law enforcement officer or agent.

(*iii*) Disclose the personal address or telephone number of active or retired law enforcement officers or agents or a special skill that they may have.

(*iv*) Disclose the name, address, or telephone numbers of family members, relatives, children, or parents of active or retired law enforcement officers or agents.

(*v*) Disclose operational instructions for law enforcement officers or agents.

(*vi*) Reveal the contents of staff manuals provided for law enforcement officers or agents.

(*vii*) Endanger the life or safety of law enforcement officers or agents or their families, relatives, children, parents, or those who furnish information to law enforcement departments or agencies.

(*viii*) Identify or provide a means of identifying a person as a law enforcement officer, agent, or informant.

(*ix*) Disclose personnel records of law enforcement agencies.

(*x*) Identify or provide a means of identifying residences that law enforcement agencies are requested to check in the absence of their owners or tenants.

(t) Except as otherwise provided in this subdivision, records and information pertaining to an investigation or a compliance conference conducted by the department of consumer and industry services under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838, before a complaint is issued. This subdivision does not apply to records or information pertaining to 1 or more of the following:

(*i*) The fact that an allegation has been received and an investigation is being conducted, and the date the allegation was received.

(*ii*) The fact that an allegation was received by the department of consumer and industry services; the fact that the department of consumer and industry services did not issue a complaint for the allegation; and the fact that the allegation was dismissed.

(u) Records of a public body's security measures, including security plans, security codes and combinations, passwords, passes, keys, and security procedures, to the extent that the records relate to the ongoing security of the public body.

(v) Records or information relating to a civil action in which the requesting party and the public body are parties.

(w) Information or records that would disclose the social security number of an individual.

(x) Except as otherwise provided in this subdivision, an application for the position of president of an institution of higher education established under section 4, 5, or 6 of article VIII of the state constitution of 1963, materials submitted with such an application, letters of recommendation or references concerning an applicant, and records or information relating to the process of searching for and selecting an individual for a position described in this subdivision, if the records or information could be used to identify a candidate for the position. However, after 1 or more individuals have been identified as finalists for a position described in this subdivision, this subdivision does not apply to a public record described in this subdivision, except a letter of recommendation or reference, to the extent that the public record relates to an individual identified as a finalist for the position.

(y) Records or information of measures designed to protect the security or safety of persons or property, whether public or private, including, but not limited to, building, public works, and public water supply designs to the extent that those designs relate to the ongoing security measures of a public body, capabilities and plans for responding to a violation of the Michigan anti-terrorism act, chapter LXXXIII-A of the Michigan penal code, 1931 PA 328, MCL 750.543a to 750.543z, emergency response plans, risk planning documents, threat assessments, and domestic preparedness strategies, unless disclosure would not impair a public body's ability to protect the security or safety of persons or property or unless the public interest in disclosure outweighs the public interest in nondisclosure in the particular instance.

(2) A public body shall exempt from disclosure information that, if released, would prevent the public body from complying with section 444 of subpart 4 of part C of the general education provisions act, title IV of Public Law 90-247, 20 U.S.C. 1232g, commonly referred to as the family educational rights and privacy act of 1974. A public body that is a local or intermediate school district or a public school academy shall exempt from disclosure directory information, as defined by section 444 of subpart 4 of part C of the general education provisions act, title IV of Public Law 90-247, 20 U.S.C. 1232g, commonly referred to as the family educational rights and privacy act of 1974, requested for the purpose of surveys, marketing, or solicitation, unless that public body determines that the use is consistent with the educational mission of the public body and beneficial to the affected students. A public body that is a local or intermediate school district or a public school academy may take steps to ensure that directory information disclosed under this subsection shall not be used, rented, or sold for the purpose of surveys, marketing, or solicitation. Before disclosing the directory information, a public body that is a local or intermediate school district or a public school academy may require the requester to execute an affidavit stating that directory information provided under this subsection shall not be used, rented, or sold for the purpose of surveys, marketing, or solicitation.

(3) This act does not authorize the withholding of information otherwise required by law to be made available to the public or to a party in a contested case under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328.

(4) Except as otherwise exempt under subsection (1), this act does not authorize the withholding of a public record in the possession of the executive office of the governor or lieutenant governor, or an employee of either executive office, if the public record is transferred to the executive office of the governor or lieutenant governor, or an employee of either executive office, after a request for the public record has been received by a state officer, employee, agency, department, division, bureau, board, commission, council, authority, or other body in the executive branch of government that is subject to this act.

History: 1976, Act 442, Eff. Apr. 13, 1977;—Am. 1978, Act 329, Imd. Eff. July 11, 1978;—Am. 1993, Act 82, Eff. Apr. 1, 1994;—Am. 1996, Act 553, Eff. Mar. 31, 1997;—Am. 2000, Act 88, Imd. Eff. May 1, 2000;—Am. 2001, Act 74, Imd. Eff. July 24, 2001;—Am. 2002, Act 130, Eff. May 1, 2002;—Am. 2002, Act 437, Eff. Aug. 1, 2002.

Popular name: Act 442

Popular name: FOIA

15.243a Salary records of employee or other official of institution of higher education, school district, intermediate school district, or community college available to public on request.

Sec. 13a. Notwithstanding section 13, an institution of higher education established under section 5, 6, or 7 of article 8 of the state constitution of 1963; a school district as defined in section 6 of Act No. 451 of the Public Acts of 1976, being section 380.6 of the Michigan Compiled Laws; an intermediate school district as defined in section 4 of Act No. 451 of the Public Acts of 1976, being section 380.4 of the Michigan Compiled Laws; or a community college established under Act No. 331 of the Public Acts of 1966, as amended, being sections 389.1 to 389.195 of the Michigan Compiled Laws shall upon request make available to the public the salary records of an employee or other official of the institution of higher education, school district, intermediate school district, or community college.

History: Add. 1979, Act 130, Imd. Eff. Oct. 26, 1979.

Popular name: Act 442

Popular name: FOIA

15.244 Separation of exempt and nonexempt material; design of public record; description of material exempted.

Sec. 14. (1) If a public record contains material which is not exempt under section 13, as well as material which is exempt from disclosure under section 13, the public body shall separate the exempt and nonexempt material and make the nonexempt material available for examination and copying.

(2) When designing a public record, a public body shall, to the extent practicable, facilitate a separation of exempt from nonexempt information. If the separation is readily apparent to a person requesting to inspect or receive copies of the form, the public body shall generally describe the material exempted unless that description would reveal the contents of the exempt information and thus defeat the purpose of the exemption.

History: 1976, Act 442, Eff. Apr. 13, 1977.

Popular name: Act 442

Popular name: FOIA

15.245 Repeal of §§ 24.221, 24.222, and 24.223.

Sec. 15. Sections 21, 22 and 23 of Act No. 306 of the Public Acts of 1969, as amended, being sections 24.221, 24.222 and 24.223 of the Michigan Compiled Laws, are repealed.

History: 1976, Act 442, Eff. Apr. 13, 1977.

Popular name: Act 442

Popular name: FOIA

15.246 Effective date.

Sec. 16. This act shall take effect 90 days after being signed by the governor.

History: 1976, Act 442, Eff. Apr. 13, 1977.

Popular name: Act 442

Popular name: FOIA

EFFECTIVE MEETINGS

ACRONYMS/DEFINITIONS

Acronym	Acronym Explained	Definition
ADA	Americans With Disability Act	A federal law that prohibits discrimination against people with physical or mental disabilities in employment, public services and places of public accommodation, such as restaurants, hotels and theaters.
	Advance Directives	Legally executed document that explains the patient's healthcare-related wishes and decisions. It is drawn up while the patient is still competent and is used if the patient becomes incapacitated or incompetent.
	Advocacy	Acting on behalf of those who are not able to speak for, or represent, themselves. It is also defending others and acting in their best interest.
AAA	Area Agency on Aging	The collective advocacy and public arm for Michigan's Area Agencies on Aging.
AARP	American Association of Retired Persons	AARP is a membership organization dedicated to enhancing the experience of aging through advocacy, information, and services.
ACCESS	Automated Client Care & Eligibility Support System	The automated system used by the Department of Human Services to determine Medicaid eligibility.
ADA	Americans with Disabilities Act	The ADA prohibits discrimination on the basis of disability in employment, state, and local government, public accommodations, commercial facilities, transportation, and telecommunications. It also applies to the United States Congress. Section 504 of the ADA states that "no qualified individual with a disability in the United States shall be excluded from, denied the benefits of, or be subjected to discrimination under" any program or activity that either receives Federal financial assistance or is conducted by any Executive agency or the United States Postal Service.
ADC	Adult Day Care	Also known as adult day services or adult day health. Adult day care services provide daytime supervision and arranged social interaction for elders. This option may allow some elders to stay at home longer by allowing caretaking spouses of children to work while knowing their loved one is in a supervised environment. Adult day care centers provide mainly non-medical services.
APS	Adult Protective Services	The division within the Department of Human Services that investigates allegations of abuse, neglect or exploitation and provides protection to vulnerable adults.
ADL	Activities of Daily Living	Activities that all people generally do habitually and universally, such as eating, bathing, dressing, grooming, toileting, transferring, mobility.
ADRC	Aging and Disability Resource Center	A comprehensive resource on long term care that provides information and assistance in accessing services, planning for long term care financing and delivery, benefits outreach and choice counseling for the general population. The ADRC will conduct medical and facilitate financial eligibility for Medicaid-funded supports and services provided in nursing facilities and the MI Choice waiver.

	Administrative hearing	Also referred to as fair hearing. An impartial review by an administrative law judge of a department decision that a consumer believes is illegal or, in the case of the community spouse, the resource or income allowance is unsatisfactory. Both the consumer and the department are given the opportunity to present evidence in support of their respective positions.
AFC	Adult Foster Care	AFCs provide 24-hour personal care, protection, and supervision to individuals not capable of independent living but not in need of continuous nursing care. Services include assistance with basic activities of daily living such as bathing, dressing, toileting, and eating. Services can also include management of existing medical conditions requiring special diets, medications, and basic medical care short of continuous or extensive skilled nursing fcare. AFC homes are limited to providing care to no more than 20 adults. These facilities must be licensed.
	Advocate	A person who speaks or writes in support of another person.
	Alternate Delivery System	Health care services or facilities that "deliver" care that is more cost effective than that provided in a hospital.
	Assessment	The process of collecting in-depth information about a person's situation and functioning to identify individual needs in order to develop a comprehensive case management plan. In addition to direct consumer contact, information should be gathered from other relevant sources.
ALF	Assisted Living Facility	These facilities help seniors who are not in need of skilled nursing assistance and who are able to live independently with minimal assistance. Services, including supervision, limited nursing care, personal care, homemaker services, and therapies are provided as needed and upon request. Assisted living units typically feature private cooking and toilet facilities, lockable doors, and single occupancy where desired.
AT	Assistive Technology	Any item, piece of equipment or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve functional capabilities of individuals with disabilities.
	Assistive Technology Service	Any service that directly assists an individual with a disability in the selection, acquisition, or use of an assistive technology device including: evaluation, purchasing, leasing, otherwise providing for acquisition, selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing or replacing, coordinating and using other therapies, interventions or services, training or technical assistance for individuals with disabilities, their family members, professionals, employers or other providers of services.
ALJ	Administrative Law Judge	An employee of the State Office of Administrative Hearings and Rules within the Department of Labor and Economic Growth. An ALJ conducts the administrative hearing.
AoA	Administration on Aging	The nation's information resource for home- and community-based care for older persons and their caregivers.
APS	Adult Protective Services	Part of the Department of Human Services

ARR	Annual Resident Review	All residents in Medicaid-certified nursing facilities must be reviewed at least annually to determine if the resident is in need of mental health services and/or continued nursing care.
	Assets	Cash, any other personal property and real property.
	Assisted Living	Assisted Living is part of the continuum of long-term care services that may provide a combination of housing, personal services, and health care designed to help individuals who need assistance with normal, daily activities (sometimes referred to as "Activities of Daily Living" or "ADLs") in a manner that promotes the person's independence. Assisted Living differs from nursing home care in that Assisted Living does not provide the 24-hour skilled nursing care offered in licensed nursing homes. Nursing homes and Assisted Living communities operate under entirely different sets of rules and regulations. The level of services and/or types of care offered varies widely
	Assistive Technology	Items which assist a person with functional limitations to complete a task. For example, a bath seat, handheld shower head, a toilet paper holder, a reacher or grabber, a lift chair, a hoyer lift.
	Authorized Representative	An individual specifically designated by the consumer to act on his behalf.
	Benefits Counseling	The provision of information and assistance designed to help people learn about and, if desired, apply for public and private benefits to which they are entitled, including but not limited to, private insurance (such as Medigap policies), SSI, Food Stamps, Medicare, Medicaid and private pension benefits
BEAM	Bringing the Eden Alternative to the Midwest	The Eden Alternative offers a method of changing the culture in long-term care communities by placing residents at the center of decision making about their care..
	Caregiver	The person responsible for hands-on care for a consumer
CBC	Citizens for Better Care	Information and advocacy to enhance the self-determination and well-being of long term care consumers.
CM	Care management	A collaborative process that assesses, plans, implements, coordinates, monitors, an devaluates the options and services required to meet an individual’s health needs, using communication and available resources to promote quality, cost-effective outcomes. Also called case management, supports coordination.
	Children’s Waiver	Provides home and community-based children under age 16 who, but for the waiver, would require care in an Intermediate Care Facility for the Mentally Retarded (ICF/MR).
	Chore Services	Non-continuous household maintenance tasks intended to increase the safety of the individual living at the residence. Tasks may include such tasks as replacing fuses, installing screens and storm windows, repairing furniture, cleaning attics, cutting grass.

CMS	Center for Medicare and Medicaid Services	The HHS agency responsible for Medicare and parts of Medicaid. Centers for Medicare & Medicaid Services has historically maintained the UB-92 institutional EMC format specifications, the professional EMC NSF specifications, and specifications for various certifications and authorizations used by the Medicare and Medicaid programs. CMS is responsible for oversight of HIPAA administrative simplification transaction and code sets, health identifiers, and security standards. CMS also maintains the HCPCS medical code set and the Medicare Remittance Advice Remark Codes administrative code set. Formerly Health Care Financing Administration
	CMS Quality Framework	Federally created and approved quality components that provide a uniform nationwide format that enables states to describe the key components of the state's quality assurance/quality improvement program in a consistent and standard manner. The focus is on participant access, participant service planning, provider capacity, participant safeguards, rights and responsibilities, outcomes and satisfaction, and system performance.
	Coinsurance	The percentage of the health insurance charge for services that you may have to pay after you pay any plan deductibles
	Community Alternatives	Agencies, outside an institutional setting, that provides care, support and/or services to people.
CMHSB	Community Mental Health Services Board	The entity responsible, at the local level, for provision of publicly-funded mental health services.
	Community Support	Community support home care services include meals on wheels, transportation, friendly visitor, emergency response system, delivery services, and health screening clinics
	Community Supported Living Arrangements	Supports to facilitate an individual's independence and promote integration into the community. These supports include assistance, support and/or training in such activities as meal preparation, laundry, activities of daily living, money management, socialization and relationship building, and leisure choice and participation in regular community activities.
	Comprehensive Assessment	The gathering of detailed information by the worker in the areas of environment, physical, cognitive, social and emotional functioning that appraises an individual on objective terms and systematically point out service needs.
CQI	Continuous Quality Improvement	A key component of total quality management that uses rigorous, systematic, organization-wide processes to achieve ongoing improvement in the quality of health care services and operations. It focuses on both outcomes and processes of care.
CR	Caregiver Respite Program	State-funded program administered through the DCH Office of Services to the Aging to provide relief to individuals providing care for a dependent individual.

CSA	Commission on Services to the Aging	The Commission on Services to the Aging consists of 15 members appointed by the governor with the advice and consent of the Senate. In addition to advocacy for senior citizens, the commissions responsibilities include reviewing and approving grants administered by the Office of Services to the Aging; designating planning and service areas and area agencies on aging within each planning and service area; and participating in the preparation and approval of the state plan and budget required by the federal Older Americans Act of 1965.
	Companion Services	Helping hands to perform light housekeeping, run errands, and attend to other needs. This is not home help services
	Consumer	An individual seeking or receiving public assistance.
	Consumer Direction	Describes programs and services where consumers have maximum choice and control over their care, often using vouchers or cash payments for the cost of services. In contrast to having care managers arrange services for clients, consumer directed care allows individual consumers to assess their own needs, determine how those needs should be met, and monitor the quality of the services they receive.
	Continuing Care Retirement Community	A residential retirement community where a variety of living and medical services are provided to residents who are in need of continuous care and/or supervision.
	Cultural Competency	A set of congruent behaviors, attitudes and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations.
	Deductible	The amount of income that must be applied to the cost of medical care before Medicaid can be authorized.
	Deinstitutionalization	The process of the return of institutionalized individuals to the community setting appropriate to their needs.
DCH	Department of Community Health	Michigan's Department of Community Health (MDCH) strives for a healthier Michigan. To that end, the department will: 1) Promote access to the broadest possible range of quality services and supports; 2)Take steps to prevent disease, promote wellness and improve quality of life; 3) Strive for the delivery of those services and supports in a fiscally prudent manner.
DHHS/HHS	Department of Health and Human Services	DHHS administers many of the "social" programs at the Federal level dealing with the health and welfare of the citizens of the United States. (It is the "parent" of CMS.)
DHS	Department of Human Services	The Department of Human Services (DHS) is Michigan's public assistance, child and family welfare agency. DHS directs the operations of public assistance and service programs through a network of over 100 county department of human service offices around the state. Formerly the Family Independence Agency.
DMB	Department of Management and Budget	Provides cost-effective business services to government
DoE	Department of Education	State Department that oversees education in Michigan.

DoLEG	Department of Labor and Economic Growth	Grow Michigan by promoting economic and workforce development, stimulating job creation and enhancing the quality of life in Michigan.
DoT	Department of Transportation	Providing the highest quality integrated transportation services for economic benefit and improved quality of life.
DD	Developmental Disability	A disability which originates before age 18, can be expected to continue indefinitely, and constitutes a substantial handicap to the disabled's ability to function normally.
DCW	Direct Care Worker	Provide hands-on long-term care and personal assistance received by citizens who are elderly, chronically ill, or
	Discharge Planning	Disposition of the patient at discharge.
DME	Durable Medical Equipment	Durable medical equipment is any equipment that provides therapeutic benefits to a patient in need because of certain medical conditions and/or illnesses and that can withstand repeated use and is primarily and customarily used to serve a medical purpose. It includes, but is not limited to, wheelchairs, hospital beds, traction equipment, canes, crutches, etc.
DV	Domestic Violence	Domestic violence and emotional abuse are behaviors used by one person in a relationship to control the other.
	Elderly Waiver	See MI Choice Waiver
	Environmental Modifications	Physical adaptations to the home and/or work place, required by the individual's support plan, that are necessary to ensure the health, safety and welfare of the individual, or enable him to function with greater independence within the environment.
	Estate Recovery	By law states are required to recover funds from certain deceased Medicaid recipients' estates up to the amount spent by the state for all Medicaid services (e.g., nursing facility, home and community-based services, hospital, and prescription costs).
EOB	Explanation of Benefits	The document sent by the health insurance plan briefly detailing health services obtained and their reimbursements.
	Family Training/Support	Training and counseling services for the families of individuals served in a home and community based waiver. Family is defined as the persons who live with or provide care to the participant, and may include parent, spouse, children, relatives, foster family, or in-laws. Training includes instructions about treatment regimens and use of equipment.
FFP	Federal Financial Participation	The federal matching monetary amount for Medicaid services. This varies with each state based on a federal formula.
FFS	Fee for Service	A billing system in which providers charge patients or are reimbursed by insurance companies for each specific service performed.
FGP	Foster Grandparent Program	The Foster Grandparent Program (FGP) offers low-income men and women aged 60 and older the opportunity to provide companionship and guidance to children with special and exceptional needs.

FPL	Federal Poverty Level	A federally-defined minimum income level below which a person is officially considered to lack adequate subsistence and to be living in poverty. Also called poverty line.
FY	Fiscal Year for Michigan	October 1 – September 30
	Functional Limitation	The extent to which a person is physically incapable of performing activities essential for self and home care.
GAO	General Accounting Office	The arm of Congress that investigates the performance of the federal government. GAO evaluates the use of public funds and the performance of federal programs, while also providing analytical, investigative and legal services in order to support to Congress in its policy formulation and decision making processes. Most GAO reports are initiated at the request of Congress, while some are initiated by the agency itself or are required by law.
	General Fund Participation	The state matching monetary amount for Medicaid services and other non federally-funded activities.
	Grants	Direct cash grants to state or local governmental units, to other public bodies established under state or local law, or to their designee.
	Group Home	(Also called adult care home or board and care home.) Residence which offers housing and personal care services for 3 to 16 residents. Services (such as meals, supervision, and transportation) are usually provided by the owner or manager. May be single family home. (Licensed as adult family home or adult group home.)
	Guardian	A person either appointed by a court or designated by a will to exercise powers over the person of an individual who is less than 18 years of age or a legally incompetent person.
	Habilitation/Supports waiver	Provides home and community-based services to developmentally disabled persons over age 18, who, but for the waiver, would require care in an Intermediate Care Facility for the Mentally Retarded (ICF/MR)
HB	House bill (state)	A proposed law introduced in the House for consideration.
HCBS	Home and Community Based Waivers	Section 2176 of the Omnibus Reconciliation Act permits states to offer, under a waiver, a wide array of home and community-based services that an individual may need to avoid institutionalization. Regulations to implement the act list the following services as community and home-based services which may be offered under the waiver program: case management, homemaker, home health aide, personal care, adult day health care, habilitation, respite care and other services.
HCBS/ED	Home and Community Based Services for the Elderly and Disabled waiver	Commonly known in Michigan as MI Choice. Also see 1915(c) waivers.
HDM	Home delivered meals	The provision of nutritious meals to homebound individuals.

HFA	Home for the Aged	Provides 24-hour room, board and supervised personal care to 21 or more unrelated, non-transient individuals 60 years of age or older. Also refers to a home for 20 or fewer individuals 60 years of age or older that is operated in conjunction with and as a distinct part of a licensed nursing home.
	Home Health Aide	A person who, under the supervision of a home health or social service agency, assists elderly, ill or disabled person with household chores, bathing, personal care, and other daily living needs. Social service agency personnel are sometimes called personal care aides.
HHA	Home Health Agency	A public or private organization that provides home health services supervised by a licensed health professional in the patient's home either directly or through arrangements with other organizations.
HH	Home Help	Medicaid service that provides assistance in conducting activities of daily living.
	Homemaking	Performance of routine household tasks to maintain an adequate living environment for older individuals with functional limitations. Does not include provision of chore or personal care services.
	Hospice	Services provided to meet the physical, psychological, social and spiritual needs of terminally ill patients. Focuses on pain control, comfort, and emotional support for the dying person and his family. Hospice facilities are licensed and certified.
HIPAA	Health Insurance Portability and Accountability Act	Federal health insurance legislation passed in 1996, which sets standards for access, portability, and renewability that apply to group coverage--both fully insured and self-funded--as well as to individual coverage. HIPAA allows under specified conditions, for long-term care insurance policies to be qualified for certain tax benefits under Section 7702(b) of the Internal Revenue Code.
HLTCU	Hospital Long Term Care Unit	Provides the same services as a nursing home, but is operated by the hospital, and is not a stand-alone facility.
HSA	Health Systems Agency	A local or area-wide healthcare planning and coordinating group established by law.
HSE	Housing with Services Establishments	The HSE has been designed to provide a pleasant, supportive environment, which enables each individual tenant to maintain his or her optimum level of independence. The HSE offers its services to all qualified persons on a non-discriminatory basis, without regard to race, color, sex, religion or national origin. The HSE offers services suitable for persons who are independent, requiring minimal assistance with daily activities but desire the amenities and services of living in an HSE. For consideration of the rent payable under the Rental Agreement, a variety of services may be provided without additional charge. Any additional service elections selected by the tenant should be set forth in a Services Addendum indicating services selected and the cost of said services.
	Independent Senior Apartments	Operate under a traditional tenant/landlord agreement. They may offer

		community events such as scheduled activities or outings. Residents of these communities must be able to take care of their daily needs, just as if they were living at home or in a traditional apartment community.
I&A	Information and Assistance	Comprehensive, objective, up-to-date, citizen-friendly, information that covers the full range of available long-term care options, options that people will use immediately (such as Medicaid services) to long-range options (such as private long term care insurance), and cover programs and services that support family caregivers, as well as any special options in the state to maintain independence or direct one's own long term support service. Assistance to accessing these options must be available.
I&R	Information and Referral	The provision of information (see I&A) and referral of individuals to other programs and benefits that can help them remain in the community, including programs that can assist a person in obtaining and sustaining paid employment.
	Informed Choice	Afford individuals with disabilities and their families the opportunity to make informed choices regarding how their needs can best be met in community or institutional settings.
IADL	Instrumental Activities of Daily Living	Activities that concern a person's ability to adapt to or function in his environment, such as laundry, housework, meal preparation, taking medication, shopping and light housework.
ILS	Independent Living Facility	Rental units in which services are not included as part of the rent, although services may be available on site and may be purchased by residents for an additional fee.
IMD	Institute for Mental Disease	A hospital, nursing facility or other institution or more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental disease.
IoG	Institute of Gerontology	Usually a part of a university that engages in research, education, and service in the field of aging. Works with other university departments, institutes, and government in collaborative research projects
LOC	Level of care	Amount of assistance required by consumers which may determine their eligibility for programs and services. Levels include: protective, intermediate, and skilled.
LOS	Length of stay	The number of days stay as an inpatient in an institution.
LTC	Long term care	Those services and supports provided to an individual in a setting of his/her choice that are evaluative, preventive, habilitative, rehabilitative or health-related in nature.

LTCI	Long term care insurance	An individual or group insurance policy, certificate, or rider advertised, marketed, offered, or designed to provide coverage for at least 12 consecutive months for each covered person on an expense-incurred, indemnity, prepaid, or other basis for 1 or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, personal, or custodial care services provided in a setting other than an acute care unit of a hospital. Long-term care insurance includes individual or group annuities and life insurance policies or riders that provide directly or supplement long-term care insurance.
	Long term care estate planning	The process of arranging one's personal and financial affairs.
	Long-term care ombudsman	An individual designated by a state or a substate unit responsible for investigating and resolving complaints made by or for older people in long-term care facilities. Also responsible for monitoring federal and state policies that relate to long-term care facilities, for providing information to the public about the problems of older people in facilities, and for training volunteers to help in the ombudsman program. The long-term care ombudsman program is authorized by Title III of the Older Americans Act.
	Long-term care supports options counseling	Resource Centers will help people make informed decisions by assisting individuals and their families in understanding how their strengths, needs, preferences, and unique situations translate into possible support strategies, plans, and tactics, based on the options available in the community.
	Managed care	A healthcare delivery approach that aims to reduce unnecessary care and control costs by using primary care doctors or caseworkers as gatekeepers who determine the medical care, both general and specialized, that a patient should get, or the range of providers that can be used.
	Managed Mental Health Care	Integrates the financing and delivery of mental health care services to covered individuals by means of: arrangements with selected providers to furnish a comprehensive set of mental health care services to members, explicit criteria for the selection of mental health care provides, and significant financial incentives for members to use providers and procedures associated with the plan. Managed care services are reimbursed via a variety of methods including capitation, fee for service, and a combination of the two.
MA	Medicaid, medical assistance	The program for medical assistance established under Title XIX of the Social Security Act, Chapter 531, Stat. 620, 42 USC 1396 to 139f, 1396g-l to 1396r-6, and 1396r-8 to 1396v, and administered by the department under the Social Welfare Act, 1939 PA 280, MCL 400.1 to 400.119b.
MAAAA	Michigan Association of Area Agencies on Aging	Michigan's statewide network of 16 Area Agencies on Aging serves hundreds of thousands of older adults and persons with disabilities each year - providing information, assistance and access to services that help.
MAID	Medical assistance identification card	The card issued to clients to verify their eligibility for medical care
MADSA	Michigan Adult Day Services Association	
MC	Medicare	The federal program providing hospital and medical insurance to people age

		65 and older and to certain ill or disabled persons. Benefits for nursing home and home health services are limited. Title XVIII of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1395 to 1395b, 1395b-2, 1395c to 1395i, 1395i-2 to 1395i-4, 1395j to 1395t, 1395u to 1395w-2, 1395w-4 to 1395zz, and 1395bbb to 1395ccc. See Title XVIII
	Medicare Prescription Drug Coverage	Part D. Provides pharmaceutical coverage under Medicare.
MCO	Managed care organization	A healthcare system that integrates the financing and delivery of mental health services to covered individuals.
MIS	Management information system	A computer system designed to help managers plan and direct business and organizational operations.
MMAP	Medicare/Medicaid Assistance Program	Michigan MMAP is a statewide health insurance education counseling and assistance program which responds to the concerns of seniors regarding Medicare, Medicare + Choice managed care, Medicaid, supplemental insurance, long-term care insurance, Medicare and Medicaid funds for long-term care, and other related benefits issues. Direct counseling services are provided by volunteers trained to help seniors understand the increasing complexities of health care coverage. Service is provided at senior citizen centers, churches, community centers, over the phone, and through home visits for those individuals with mobility limitations.
MPRO	Michigan Peer Review Organization	A recognized leader in health care quality improvement, utilization review, data analysis, research, clinical outreach, and consumer education. Their goal is to improve the quality of health care while ensuring that it is delivered in a timely, cost-effective manner. We work with federal and state agencies, private industry, managed care organizations, trade associations, health care networks, provider groups, academic institutions, and employer and purchaser coalitions.
MQCCC	Michigan Quality Community Care Council	The Michigan Quality Community Care Council (QC3) is a public body formed to help make sure that home care workers are available for consumers. Consumers may find a provider from a list (called the Registry) the QC3 will have. Home Help consumers will still be able to find, hire, train, and fire their in-home care provider. The QC3 may also help by assisting providers in getting training.
MDS	Minimum Data Set	The core assessment items necessary for a comprehensive assessment of a nursing home resident. This includes individual assessment items and specifies definitions, time frames, and exclusions for the items as well as the response codes needed to ensure accurate assessment. It covers a wide rage of functional domains, such as the resident's status in terms of cognition, communication, activities of daily living, continence, psychosocial well-being, disease diagnoses, and health conditions.
MRT	Medical review team	A team composed of medical professionals and consultants that certifies the consumer's medical eligibility for assistance.
MSA	Medical Services Administration	The agency within the Department of Community Health that is responsible for administration of the Medicaid program.
	MI Choice Waiver Program	Waiver program that provides home and community-based services to the

		aged and disabled persons who, if they did not receive such services, would require care in a nursing home.
MSG	Michigan Society of Gerontology	A voluntary organization made up of Michigan citizens who are concerned with education, research, action and service on behalf of older people in Michigan. MSG provides a multi-disciplinary forum for the exchange of ideas among diverse groups of professionals and students.
MSHDA	Michigan State Housing Development Authority	Provides financial and technical assistance through public and private partnerships to create and preserve decent, affordable housing for low- and moderate-income Michigan residents.
	Model payments system	The computer system that maintains home help provider files and initiates provider checks to home help providers
n4A	National Association of Area Agencies on Aging	The umbrella organization for the 655 area agencies on aging (AAAs) and more than 230 Title VI Native American aging programs in the U.S. Through its presence in Washington, D.C., n4a advocates on behalf of the local aging agencies to ensure that needed resources and support services are available to older Americans. T he fundamental mission of the AAAs and Title VI programs is to provide services which make it possible for older individuals to remain in their home, thereby preserving their independence and dignity. These agencies coordinate and support a wide range of home- and community-based services, including information and referral, home-delivered and congregate meals, transportation, employment services, senior centers, adult day care and a long-term care ombudsman program.
NAPIS	National Aging Programs Information System	Developed by AoA, this is a reporting procedure for use by State and Area Agencies on Aging.
NASUA	National Association of State Units on Aging	A non-profit association representing the nation's 56 officially designated state and territorial agencies on aging. The mission of the Association is to advance social, health, and economic policies responsive to the needs of a diverse aging population and to enhance the capacity of its membership to promote the rights, dignity and independence of, and expand opportunities and resources for, current and future generations of older persons, adults with disabilities and their families.
NCBA	National Center on Black Aged	The National Caucus and Center on Black Aged, Inc. has one mission: "To improve the quality of life for elderly African Americans and low income minorities."
NCOA	National Council on Aging	A national network of organizations and individuals dedicated to improving the health and independence of older persons and increasing their continuing contributions to communities, society and future generations.

NCSC	National Council of Senior Citizens	The National Council of Senior Citizens is an advocacy organization which comprises over 2,000 senior citizens clubs. It speaks out on behalf of the elderly and is one of the largest sponsors of housing for low-income elderly and handicapped people.
NF	Nursing facility	Facility licensed by the state to offer residents personal care as well as skilled nursing care on a 24 hour a day basis. Provides nursing care, personal care, room and board, supervision, medication, therapies and rehabilitation. Rooms are often shared, and communal dining is common. (Licensed as nursing homes, county homes, or nursing homes/residential care facilities.)
NFCSP	National Family Caregiver Support Program	The enactment of the Older Americans Act Amendments of 2000 (Public Law 106-501) established an important new program, the National Family Caregiver Support Program (NFCSP). The program was developed by the Administration on Aging (AoA) of the U.S. Department of Health and Human Services (HHS)
NIA	National Institute on Aging	NIA, one of the 27 Institutes and Centers of NIH, leads a broad scientific effort to understand the nature of aging and to extend the healthy, active years of life. In 1974, Congress granted authority to form NIA to provide leadership in aging research, training, health information dissemination, and other programs relevant to aging and older people. Subsequent amendments to this legislation designated the NIA as the primary Federal agency on Alzheimer's disease research.
NSSC	National Senior Service Corps	The National Senior Service Corps (Senior Corps) is a network of federally-supported programs that helps people age 55 and older find service opportunities in their home communities. The Senior Corps involves seniors in three types of service: the foster grandparent program; senor companions, and retired and senior volunteers.
	Nursing Care	See Level of Care
	Nursing Care Facility	A facility providing skilled or intermediate nursing care which must be state-licensed.
OAA	Older Americans Act	Federal legislation that specifically addresses the needs of older adults in the United States. Provides some funding for aging services (such as home-delivered meals, congregate meals, senior center, employment programs). Creates the structure of federal, state, and local agencies that oversee aging services programs.
OAVP	Older American Volunteer Program	All the senior service programs administered by the Corporation: Senior Companions, Foster Grandparents, and Retired and Senior Volunteer Program (RSVP). Also called Senior Corps. Formerly called the National Senior Volunteer Corps and before that the Older American Volunteer Program

OBRA	Omnibus Budget Reconciliation Act (OBRA) of 1993	Federal legislation that limits the amount of compensation that can be paid to employees covered by long-term disability plans funded through voluntary employees' beneficiary association trusts. Any such plan with participants earning more than $150,000 could lose its tax-exempt status.
OHCDS	Organization health care delivery system	A public or private organization that delivers health care services. Includes but is not limited to: a clinic, a group practice prepaid capitation plan and a health management organization. An entity to which Medicaid payment can properly be made.
OMB	Office of Management and Budget	OMB's predominant mission is to assist the President in overseeing the preparation of the federal budget and to supervise its administration in Executive Branch agencies. In helping to formulate the President's spending plans, OMB evaluates the effectiveness of agency programs, policies, and procedures, assesses competing funding demands among agencies, and sets funding priorities. OMB ensures that agency reports, rules, testimony, and proposed legislation are consistent with the President's Budget and with Administration policies. In addition, OMB oversees and coordinates the Administration's procurement, financial management, information, and regulatory policies. In each of these areas, OMB's role is to help improve administrative management, to develop better performance measures and coordinating mechanisms, and to reduce any unnecessary burdens on the public.
OSA	Office of Services to the Aging	Coordinates and administers all state activities related to older persons in accordance with the requirements of the federal Older Americans Act and the state Older Michiganians Act. Establishes service standards, provides information, education and assistance to elders, caregivers and families. Targets services to elders who are frail, low income and at risk of losing their independence. Delivers services through a network of innovative public/private partnerships that include area agencies on aging and hundreds of local service providers.
OWL	Older Women’s League	As the only national grassroots membership organization to focus solely on issues unique to women as they age, OWL strives to improve the status and quality of life of midlife and older women. OWL is a nonprofit, nonpartisan organization that accomplishes its work through research, education, and advocacy activities conducted through a chapter network.

	Ombudsman Program	The Long-Term Care Ombudsman Program is a system of state and local advocacy services designed to address issues and problems faced by residents of licensed long-term care facilities. Michigan's Long-Term Care Ombudsman assists residents of nursing homes, homes for the aged, adult foster care homes, and their families and friends who have questions and complaints. Ombudsmen can also provide information about the Medicare and Medicaid systems and information about LTC policy and government regulations. In addition ombudsman staff can explain the different kinds of care, how to find it, how it is paid for and information on specific facilities.
PA	Public Act	An act or statute affecting matters of public concern. Of such statutes the courts take judicial notice.
PACE	Program of All-Inclusive Care for the Elderly	A capitated benefit that features a comprehensive service delivery system and integrated Medicare and Medicaid financing for frail, elderly individuals that meet long term care level of care criteria. For most PACE participants, the comprehensive service package permits them to continue living at home while receiving services rather than being institutionalized.
PASAAR	Pre-Admission Screening & Annual Resident Review	A two-level screening and evaluation process to determine the needs for a nursing facility level of care.
PC	Personal care	See home help
PCA	Personal care attendant	See direct care worker
PCP	Person centered planning	A process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and that honors the individual's preferences, choices, and abilities. The person-centered planning process involved families, fiends, and professional as the individual desires or requires.
PERS	Personal Emergency Response Systems	A service system using electronic devices designed to monitor consumer
PES	Participant Experience Survey	A series of population-specific interview tools that capture data that can be used to calculate indicators for monitoring quality within the waiver programs. Each survey is designed to be conducted as a face-to-face interview.
POA	Power of Attorney	An instrument authorizing another to act as one's agent or attorney. The agent is attorney in fact and his power is revoked upon the death of the principal by operation of law.
POSM	Participant Outcome Survey	The project is developing a quality of life survey instrument to be used in long-term care programs. The instrument addresses area such as the availability of paid supports, relationships with support workers, meaningful activities, community integration, personal relationships, dignity and respect, autonomy, privacy and security.
PPA	Patient pay amount	The monthly amount of a person's income that Medicaid considers available for meeting the cost of hospital or nursing facility services.

PSA	Planning and Service Area	The geographic area, consisting or one or more counties, for which an agency is designated to plan for and provide services under the Older American Act.
	Personal Needs Allowance	The amount of money an institutionalized person may use for personal items such as barber services.
	Personal residence	The consumer's own home, rental, or apartment, including an assisted living facility. Caregivers come to the home of the consumer to provide services ranging from basic assistance to skilled medical care.
	Provider	A person or agency that furnishes a service to a consumer.
	Quality Assurance	The use of activities and programs to ensure the quality of patient care. These activities and programs are designed to monitor, prevent, and correct quality deficiencies and noncompliance with the standards of care and practice.
QC3	Quality Community Care Council	The entity that was created to provide support to direct care workers and provide a Registry of such workers for consumers to access.
	Qualified Continuing Care Facility	Means 1 or more facilities **(i)** which are designed to provide services under continuing care contracts, and **ii)** substantially all of the residents of which are covered by continuing care contracts.
	Quality Indicators	Quality measures that provides information about how well a provider renders care for some of their patients. The measures provide information about patients' physical and mental health, and whether their ability to perform basic daily activities is maintained or improved. Quality information can be used to help compare providers.
QI	Quality Improvement	An array of techniques and methods used for the collection and analysis of data gathered in the course of current health care practices in a defined care setting to identify and resolve problems in the system and improve the processes and outcomes.
QMS	Quality Monitoring System	A system used to ensure that care is being delivered at or above acceptable quality standards and as identified by the agency, organization or national guidelines.
	Rehabilitation Facility	An inpatient institution or distinct part rehabilitation unit in an institution licensed under applicable state laws and engaged in primarily in providing intensive rehabilitative services.
	Regional Office	Regional office of the Centers for Medicare and Medicaid Services, Region V
RAI	Resident Assessment Instrument	A uniform assessment system used to assess and plan the care of residents in most U.S. nursing homes. It is a federally-mandated system as part of the Omnibus Budget Reconciliation Act 01 1987.
RAP	Resident Assessment Protocols	Guidelines for additional, more sharply focused assessment and care planning. The MDS triggers use of the RAPs by identifying residents who need more specific assessment.

	Residential Care	The provision of room, board and personal care. Residential care falls between the nursing care delivered in skilled and intermediate care facilities and the assistance provided through social services. It can be broadly defined as the provision of 24-hour supervision of individuals who, because of old age or impairments, necessarily need assistance with the activities of daily living.
RFI	Request for Information	A document that invites a vendor to submit a bid for hardware, software and/or services. It may provide a general or very detailed specification of the system.
RFP	Request for Proposal	A document which describes an opportunity to acquire grant funds for a specific purpose. The RFP also describes the requirements for applying for the grant.
RSVP	Retired and Senior Volunteer Program	The Retired and Senior Volunteer Program (RSVP) offers senior citizens a meaningful life in retirement through volunteer service that is responsive to community needs. RSVP provides opportunities for persons aged 55 and older to serve on a regular basis in a variety of settings throughout their communities.
RUGS	Resource Utilization Groups	Classifies skilled nursing facility patients into 7 major hierarchies and 44 groups. Based on the MDS, the patient is classified into the most appropriate groups, and with the highest reimbursement.
	Respite	Provision of companionship, supervision and/or assistance with activities of daily living for individuals in the absence of the primary caregiver.
RSDI	Retirement, Survivors and Disability Insurance	RSDI is a program administered under Title II of the Social Security Act through the SSA that pays benefits to persons who have contributed enough quarters to the Social Security system, or who are the dependents of one who has contributed to the system, when they are aged or retired, are a surviving spouse or dependent child, or are disabled. An individual under age 65 receiving RSDI as a retired person must be determined disabled to be eligible under MAD. Receipt of early retirement benefits does not establish disability, unless the individual actually received a disability benefit and then switched to early retirement benefits at age 62. For individuals receiving early retirement benefits, verify with SSA whether he has been determined disabled.
	Self Determination	Self-determination is the freedom to make individual choices about one's own life and the opportunity to fail, just like any other person.
	Senior Housing	Typically apartment buildings or complexes reserved for senior living. Services may include arranged group social activities, group meals and limited services such as laundry or transportation. These are not health care facilities but rather housing arrangements targeted to the needs of seniors. Senior housing complexes are run by both private and non-profit organizations.
SAC	State Advisory Council on Aging	The Council focuses on information and assistance services in the aging

		network, among other issues of interest to aging population of Michigan.
SB	Senate Bill	A proposed law introduced in the Senate for consideration.
	Senior Center	Provides a variety of on-site programs for older adults including recreation, socialization, congregate meals, and some health services. Usually a good source of information about area programs and services.
SCP	Senior Companion Program	The Senior Companion Program (SCP) offers low-income men and women aged 60 and older the opportunity to provide individualized care and assistance to other adults, especially seniors living at home or in institutions.
SEAQRT	Senior Exploitation and Abuse Quick Response Team	A coalition of state level agency representative and private sector professionals to make available the collective expertise of its membership to local advocates in need of assistance on cases involving expoitatino of vulnerable adults.
SILP	Supported Independent Living Program	
SMSA	Standard Metropolitan Statistical Area	One or more cities or counties designated by the Department of Commerce as an integrated economic and social unit with a large population nucleus.
SNF	Skilled Nursing Facility	An institution (or a distinct part of an institution) which is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons, and is not primarily for the care and treatment of mental diseases; has in effect a transfer agreement (meeting the requirements of §1861(1) with one or more hospitals having agreements in effect under §1866; and meets the requirements for a SNF described in subsections (b), (c), and (d) of this section.
SPE	Single Point of Entry	A system that enables consumers to access long-term and supportive services through one agency or organization. These organizations manage access to one or more funding sources and perform a range of activities that may include information and assistance, preliminary screening or triage, nursing facility preadmission screening, assessment of functional capacity and service needs, care planning, service authorization, monitoring, and re-assessment.
SR	Senate bill	A proposed law introduced in the Senate for consideration.
SSN	Social Security Number	A Social Security number identifies each person's record so that wages or self-employment income reported can be properly credited to the individual's record. The number is also used when determining entitlement to benefits.
SSA	Social Security Administration	SSA is the agency of the federal government that issues regulations for the RSDI and SSI programs, as well as Medicare and Medicaid, under the Social Security Act.
SSI	Supplemental Security Income	SSI is a program administered under Title XVI of the Social Security Act through the SSA. It is an assistance program based on need that guarantees a minimum level of income for aged, blind, and disabled persons. SSI recipients have not contributed enough to the Social Security system to be able to receive benefits on their own wage accounts.
SSDI	Supplemental Security Disability Income	A system of federally provided payments to eligible workers (and, in some cases, their families) when they are unable to continue working because of a

		disability. Benefits begin with the sixth full month of disability and continue until the individual is capable of substantial gainful activity.
SUA	State Unit on Aging	Authorized by the Older Americans Act. Each state has an office at the state level which administers the plan for service to the aged and coordinates programs for the aged with other state offices.
	Supports coordination	Involves working with the waiver participant and others identified by the consumer, in developing a person-centered plan. Using person-centered processes, supports coordination assists in identifying and implementing support strategies to incorporate the principles of empowerment, community inclusion, health and safety assurances, and the use of natural supports.
	Subacute Care	(Also called post-acute care or transitional care.) Type of short-term care provided by many long-term care facilities and hospitals which may include rehabilitation services, specialized care for certain conditions (such as stroke and diabetes) and/or post-surgical care and other services associated with the transition between the hospital and home. Residents on these units often have been hospitalized recently and typically have more complicated medical needs. The goal of subacute care is to discharge residents to their homes or to a lower level of care.
	Supplemental Medical Insurance Coverage	Private health insurance, also called medigap, designed to supplement Medicare benefits by covering certain health care costs that are not paid for by the Medicare program.
TA	Technical assistance	The provision of technical expertise to assist in the preparation or implementation of a project or a policy. It is also given to help in the development of institutions or human resources.
TBI	Traumatic brain injury	A nondegenerative, noncongenital insult to the brain from an external mechanical force, possibly leading to permanent or temporary impairments of cognitive, physical, and psychosocial functions with an associated diminished or altered state of consciousness.
	Traumatic Brain Injury (TBI) Unit	A nursing home or hospital may offer “special care units” and indicate that these provide services for a specific condition. In this case, for individuals needing services as the result of a traumatic brain injury.
TCM	Targeted case management	A set of planning, coordinating and monitoring activities that assist Medicaid recipients in the target group to access needed housing, employment, medical, nutritional, social, education, and other services to promote independent living and functioning in the community.
	Third Party Resource	An individual or entity that is, or may be, liable for all or part of a consumer’s medical expenses.

	Transition Services	(Also called subacute care or post-acute care.) Type of short-term care provided by many long-term care facilities and hospitals which may include rehabilitation services, specialized care for certain conditions (such as stroke and diabetes) and/or post-surgical care and other services associated with the transition between the hospital and home. Residents on these units often have been hospitalized recently and typically have more complicated medical needs. The goal of subacute care is to discharge residents to their homes or to a lower level of care.
	Trusts	Any arrangement in which a grantor transfers property to a trustee with the intention that it be held, managed, or administered by the trustee for the benefit of the grantor or certain designated persons. They trust must be valid under state law and manifested by a valid trust instrument or agreement.
	Uniform Functional Assessment	A process approved by the Department which measures a person's need for services because the person cannot perform activities of daily living based upon criteria which include physical or mental illness, prescribed medication, sensory impairment, disability, incapacity, psychosociological skills, interpersonal skills, assistance devices required, and available support systems. It is the same assessment regardless of setting.
USDA	United States Department of Agriculture	The federal agency that monitors food stamps and food commodities.
	Ventilator Dependent Unit	A nursing home or hospital may offer “special care units” and indicate that these provide services for a specific condition. In this case, for individuals needing ventilator dependent services.
VA	Veteran’s Administration	A federal government agency that, among other things, aids veterans of the U. S. armed forces in obtaining housing. VA loans offer a guarantee to the lending institution as to repayment of the loans and result in veteran home buyers being able to obtain mortgage loans with a lower down payment.
WC	Worker’s Compensation	State-mandated system under which employers assume the cost of medical treatment and wage losses for employees who suffer job-related illnesses or injuries, regardless of who is at fault. In return, employees are generally prohibited from suing employers, even if the disabling event was due to employer negligence. U.S. government employees, harbor workers, and railroad workers are not covered by state workers' compensation laws, but instead by various federally administered laws.
	209(b) State	The section of the Social Security Act that allows a State to use more restrictive requirements than SSI to determine Medicaid eligibility.
	1115 Waiver	Section 1115 of the Social Security Act; provides the Secretary of Health and Human Services (federal) with broad authority to authorize experimental, pilot, or demonstration projects which, in the judgment of the Secretary are likely to assist in promoting the objectives of the Medicaid statute.
	1634 State	The section of the Social Security Act that allows a State to use the same eligibility requirements as SSI to determine Medicaid eligibility.
	1915(b) Freedom of Choice Waiver	Section 1915(b) of the Social Security Act; provides that the Secretary of

		Health and Human Services (federal) may waive such requirements as statewideness, comparability of services and freedom of choice.
	1915(c) Home and Community Based Services Waiver	Section 1915(c) of the Social Security Act; provides that the Secretary of Health and Human Services (federal) may authorize a state to provide specified home and community based services in lieu of institutional care.
	1915(b)(c) Waiver	While these are considered two separate waivers by the Secretary of Health and Human Services (federal), use of these waivers allow a state to provide long-term care services (including nontraditional community-based services) in a managed care environment or by using a limited pool of providers.

RESOURCES

RESOURCE GUIDE
ASSOCIATIONS AND TRADE ORGANIZATIONS

Administration on Aging, federal agency
Agency for Health Care Policy & Research US DHHS
Alzheimer Association;
American Association of Homes for the Aging
American Association of Homes and Services for the Aging
American Association of Retired Persons
American Geriatrics Society
American Hospital Association
American Health Care Association
American Medical Association
American Osteopathic Association
American Public Health Association
American Public Welfare Association
Americans Disabled for Attendant Programs Today (ADAPT)
American Seniors Housing Association
American Society on Aging
Area Agency on Aging
Assisted Living Facilities Association of America
Association of Retired Citizens
Brain Injury Association of Michigan
Citizens for Better Care
Commission of Accreditation of Rehabilitation Facilities
Community Assistive Technology Councils
Council on Accreditation of Services for Families & Children
Elder Law of Michigan
Health Care Association of MI
MI Assisted Living Association
MI Assistive Technology Clearing House
MI Association of Areas on Aging
MI Association of Centers for Independent Living
MI Association of Community Mental Health Boards
MI Association of Durable Medical Equipment Contractors
MI Association of Homes and Services for the Aging
MI Association for Local Public Health
MI County Medical Care Facility Council
MI County Social Services Workers Association
MI Disability Rights Organization
MI Home Health Association
MI Health & Hospital Association
MI Hospice and Palliative Care Organization
MI Intertribal Council
MI Office of State LTC Ombudsman
Michigan Poverty Law
MI League for Human Services
MI Protection and Advocacy Services
MI Statewide Independent Living Council
National Academy of State Health Policy
National Association of Community Health Centers
National Association of Medical Equipment Suppliers
National Association of State long term care Ombudsman Programs
National Citizens Coalition for Nursing Home Reform (D.C.)
National Council on the Aging, Inc.
National Institute on Aging
Office of Research and Development, HCFA
Older Women's League
Paralyzed Veterans of America
Service Employees International Union
United Cerebral Palsy of Michigan
United Seniors for Action, National
Veterans Administration, federal

White House Conference on Aging, fed DHHS
60 Plus, Sixty Plus, senior citizens advocacy organization

RESOURCE GUIDE
LEGISLATION

Americans with Disabilities Act
Administrative Procedures Act
Commerce Clearing House, Chicago; federal medical law and regulations
Congressional Federal Register, or Code of Federal Regulations
Consolidated Omnibus Budget Reconciliation Act '86
Employee Retirement Income Security Act, federal, '74
Freedom of Information and Privacy Act, federal
Health Care Quality Improvement Act
Individuals with Disabilities Education Act
Nursing Home Reform Law
Older Americans Act, feds
Omnibus Budget Reconciliation Act, federal, '81, '87, '90, etc.
Patient Self Determination Act, federal '90

RESOURCE GUIDE
DEPARTMENT/AGENCIES

Adult Community Placement, Div. of OAS, DHS
Adult Protective Services, MI DHS
Alternative Health Care Financing & Delivery System, PHA, MDCH,
Assistance Payments, MI DHS
Audits, Investigations, and Licensing Administration, MI DHS
Chicago Regional State Letter, HCFA Region V
Community Public Health Agency, DCH
Department of Health and Human Services, federal
MI Department of Community Health
MI Department of Human Services
MI Department of Information Technology
MI Department of Management & Budget
Health and Welfare Data Center
Health Care Financing Administration, federal
Health, Resource and Services Administration, fed
Health Standards Quality Board, federal HCFA, DHHS
Local Health Dept
Locally Based Services, CSHCS
Local MI Department of Human Services Offices
Long-Term Care Commission
Medicare Medicaid Assistance Program
Office of Adult Services, DHS
Office of LTC Supports and Services
Office of Services to the Aging, MI
Opportunity and Skills Training program , MI DHS
Physical Disabilities Services, Div. of OAS, MI DHS
Program Administrative Manual, MI DHS
Program Eligibility Manual, DHS
Program Reference Manual, DHS
Robert Woods Johnson Foundation
Social Security Administration, federal
Title V, for children with disabilities, Soc. Sec. Act
Title XVIII (18), for people over 65 years of age, Soc. Sec. Act
Title XIX (19), for people who are low income, Soc. Sec. Act
Vocational Rehabilitation